CONTENTS

For October, 1935

COVER PAGE—Guy's Hospital, London, England

ORIGINAL ARTICLES

Social Consciousness—By-Product of Voluntary Hospitals 37
Charles H. Schweppe

For the Price of a Paper a Day 41
Maxwell Hahn

Planning the Radiologic Department 45
R. A. Rendich, M.D. and C. B. Braestrup, P.E.

The Bronx Formula—Volume Up, Costs Down 52
Raymond P. Sloan

Protecting Your Employees 57
Lee K. Frankel, Jr.

Wider Service to Doctors—A Key to Better Occupancy 61
Nathan S. Davis III, M.D.

A Nursing Curriculum That Broadens the Student's Background 65
Grace J. Kellock

Housing Act Will Aid Hospitals 71
Robert B. Smith

Report of Convention of the American Hospital Association and Allied Groups 72

Day by Day in the Hospital Pharmacy 84
I. Rogin, Ph.G.

Sound Absorption, Insulation and Air Control: An Important Trio 88
Edward F. Stevens

Comparative Study of Raw Food Costs 94
J. J. Weber

November Dinner Menus for the Staff 106
Amy Colescott

Just in Passing—

THE subject of our cover design this month is Guy's Hospital, London, founded in 1725 "at the sole costs and charges of Thomas Guy Esquire, for the reception of 400 sick persons or upwards laboring under any distempers, infirmities or disorders thought capable of relief by physick or surgery." The founder's endowment invested according to the terms of his will enabled the hospital to carry on until 1883 without appealing for public support. The reproduction on our cover is from an engraving made about 1780.

DOG-EATING men aren't the only news-makers. When a hospital trustee outlines clearly and succinctly the values of voluntary hospitals in building a community's social consciousness that also is news. Mr. Schweppe, prominent Chicago banker, makes such news in this month's leading article. Every trustee of your hospital should study this article.

AND while you have the trustee in a corner, you might ask him to try out his teeth on Doctor Davis' article, also in this issue. If he is a real trustee he will be immediately interested — for this is the kind of problem in which real trustees are interested.

WHILE we are on the subject of trustees, you might want to give yours a reprint of the series of five articles on "Distinguished Service in the Hospital." Although we can't promise that there will be any of these available for gen-

Published the first of each month by
THE MODERN HOSPITAL PUBLISHING CO., Inc.
Charter member Audit Bureau of Circulations
919 NORTH MICHIGAN, CHICAGO—Telephone, Superior 6402
NEW YORK OFFICE—101 Park Avenue. Telephone, Ashland 4-2445
SUBSCRIPTION—United States and Possessions, $3.00. Canada and Foreign, $4.00.
Single copies (current), 35 cents. Back copies, 50c to $1.00.

Copyright, 1935, by THE MODERN HOSPITAL PUBLISHING CO., INC.

Entered as second-class matter Oct. 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879.
Printed in U. S. A.

CONTENTS

eral distribution, we will fill requests without charge as long as the supply lasts.

LAST year much interest was evinced in a little article about the new, completely air conditioned Wyatt Clinic in the Arizona desert. In response to a question by one of the architectural evaluators on the practicality and economy of the air conditioning equipment, the architect and owner promised to give a report after the first year's operation. This report will appear in the November issue.

THE new series of articles on the administration of mental hospitals, which was originally scheduled to start in October, has been held over for the November issue. Dr. Clarence O. Cheney, president, American Psychiatric Association, will introduce the series, which is being edited by the committee on public education of the association. Doctor Cheney is medical director of the New York State Psychiatric Institute and Hospital, New York City.

MICHAEL Reese Hospital, Chicago, owes much of its preeminence to its willingness to encourage new and valuable types of work by its medical staff. This is one of the surest roads to distinguished service. Next month Dr. William Thalhimer will describe the work of the Samuel Deutsch Convalescent Serum Center at Michael Reese. One aspect of the center's work was recently described in the J. A. M. A.

UP IN Minnesota they believe good housing is essential to good health and good work. So they have recently built a new nurses' home that embodies their faith. Its description next month will be worth reading.

DO YOUR patients read? What? And why? Dr. Gerald Webb thinks that good reading may be excellent therapy. From so successful a practitioner, this opinion carries weight. He will present it next month.

WE ARE all striving to reach some sort of standards. One of the most recent groups

EDITORIALS

Encouraging Hospital Research 68
Securing Consent for Operation 68
An Enlarged Editorial Board 68
The Sick Employee 69
What Is a Charitable Institution? 69
Why Not Monthly Round Tables? 70
What's in a Name? 70
Hospitals and the Housing Act 70

THE HOSPITAL BAROMETER 8

WHAT OTHERS ARE DOING 60

PLANT OPERATION

Day by Day in the Hospital Pharmacy 84
Sound Absorption, Insulation and Air Control: An Important Trio 83
Grind and Wax Wooden Floors 92
A Floor Testing Machine 92

FOOD SERVICE

Comparative Study of Raw Food Costs 94
Food for Thought 104
November Dinner Menus for the Staff 106

NEWS IN REVIEW 108

NAMES IN THE NEWS 120

LITERATURE IN ABSTRACT 124

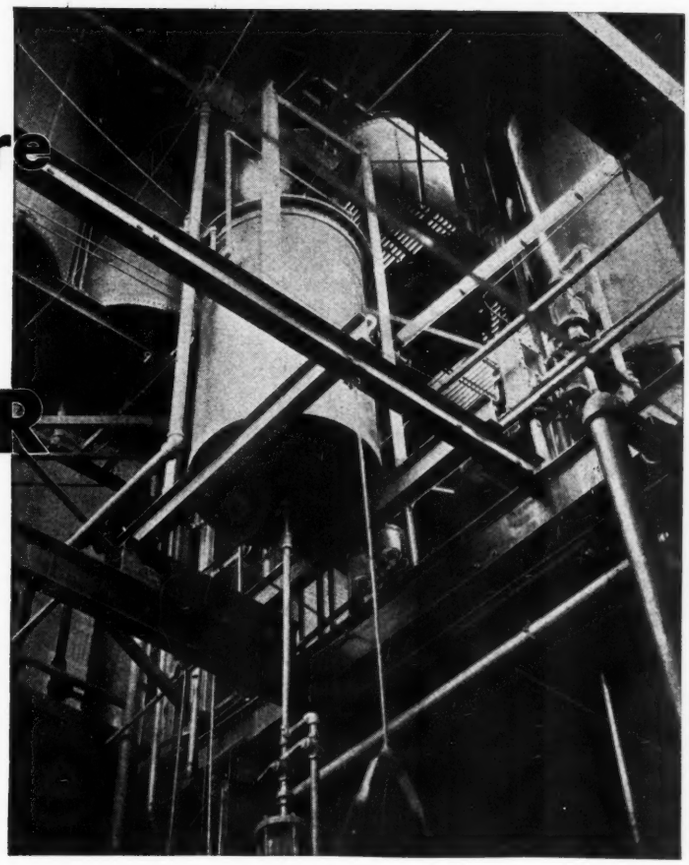
BOOKS ON REVIEW 126

NOTES FOR BUYERS 128

MISCELLANEOUS

Keeping Windows Clean 40
Catgut Waste Called Appalling 44
"Radium Hen" Helpful in Guarding Radium Supply 51
Meeting the Problem of Cracked and Scaled Paint 59
Plans for Photomicrographic Dark Rooms 64
Liability of Charitable Hospitals for Unauthorized Autopsies 67

Minimum exposure *protects* SQUIBB ETHER



STUDIES have proved that the exposure of pure anesthetic ether to the atmosphere results in the formation of peroxides and aldehydes. These in turn may cause untoward post-operative effects.

Two precautions employed by the Squibb Laboratories in the manufacture of anesthetic ether definitely protect the product against these impurities. Copper and brass piping convey the ether from the point of distillation to the subdividing and packaging plant where the cans are filled, weighed and promptly sealed hermetically with a mechanical closure. A very important feature of Squibb Ether is the patented copper-lined container in which it is packaged. This container, it has been shown, not only prevents the formation of aldehydes and peroxides, but protects its original purity indefinitely.

These precautions, in addition to careful selection of raw materials, exacting standards of manufacture and adequate control testing of the finished product, assure the surgeon and the anesthetist of an unusually pure, effective and uniform anesthetic ether—the kind which is used with confidence in millions of cases every year—Squibb Ether. *For literature descriptive of Squibb Ether send the coupon below.*

OTHER SQUIBB ANESTHETICS—Procaine Hydrochloride Crystals, Chloroform.

SQUIBB ETHER

E. R. Squibb & Sons, *Anesthetic Dept.*,
7810A Squibb Building, New York City

Please send me a copy of your illustrated booklet, "A Suggested Technique for Ether Administration."

Name .....

Street .....

City ..... *State* .....

to set up formal standards of competence and training are the laboratory technicians. What the standards are and why they have been adopted are to be described next month by Dr. Kano Ikeda.

THE Institute for Hospital Administrators, which closed on September 25, was the third such course to be given by the A. H. A. and the University of Chicago. Is it worthwhile? Next month one of the students will give his opinion.

FLASHES FROM THIS ISSUE:

"The amendment to the National Housing Act which raises the limit for an individual loan to $50,000 now makes the act of definite value to hospitals." *Pages 70 and 71.*

"Perhaps one of the causes of discontent among hospital workers lies in the fact that low wages permit of no feeling of security in the event of premature death. Sickness, accident and disability, when they afflict the hospital employee, will be relieved in most cases by the institution itself, but his sudden death, whether sustained in the job or not, hits the employee's family with a jolt which the average employing hospital is in no position to alleviate." *Page 57.*

"I started out by getting one man a week a job into which he could step when he was able to go back to work. Now I'm trying to make two jobs for two men a week. And if I ever get back to the place where I can do it, I'm going to try to establish some kind of employment bureau for patients who are able to work when they are discharged from our hospital." *Page 39.*

"The hospital is fortunate in having in the post of liaison officer a soft-spoken English woman whose sole duty it is to visit with the patients to see that they are as happy and comfortable as possible under the circumstances and to make note of any complaints they may have. She never wears a nurse's uniform. Simple street clothes, it is found, encourage confidences. Each day she makes her complete rounds." *Page 56.*

"A study of these figures, especially for meats, comparing them with the figures of any other hospital should enable the hospital executive, in cooperation with his dietitian, to determine whether food costs can be advantageously reduced by the more frequent use of one kind of raw food in preference to some other more expensive kind." *Page 94.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
OTHO F. BALL, M.D., *President*
919 NORTH MICHIGAN, CHICAGO, ILLINOIS

JOSEPH C. DOANE, M.D., *Editor*
ALDEN B. MILLS, *Managing Editor*
RAYMOND P. SLOAN, *Associate Editor*
JANET PETERKIN, *Associate Editor*

EDITORIAL BOARD

Planning and Construction
S. S. GOLDWATER, M.D.
C. W. MUNGER, M.D.

Administration
A. C. BACHMEYER, M.D.
FRED G. CARTER, M.D.

Equipment and Maintenance
E. M. BLUESTONE, M.D.
ADA BELLE MCCLEERY, R.N.

Professional Relations
M. T. MACEACHERN, M.D.
WILLARD C. RAPPLEYE, M.D.

Mental Hospital Administration
J. ALLEN JACKSON, M.D.
WILLIAM A. WHITE, M.D.

Public Health
W. S. RANKIN, M.D.
B. W. BLACK, M.D.

Public Relations
ASA S. BACON
R. C. BUERKI, M.D.

Out-Patient Service
MICHAEL M. DAVIS, PH.D.
A. K. HAYWOOD, M.D.

EDITORIAL CONSULTANTS

G. HARVEY AGNEW, M.D.
Canadian Hospital Council, Toronto, Canada

E. MURIEL ANSCOMBE
Jewish Hospital, St. Louis

ANNA E. BOLLER
Rush Medical College, Chicago

ALBERT W. BUCK, PH.D.
New Haven Hospital, New Haven, Conn.

L. H. BURLINGHAM, M.D.
Barnes Hospital, St. Louis

CAROLYN E. DAVIS, R.N.
Good Samaritan Hospital, Portland, Ore.

H. L. EASON, C.B., C.M.G., M.D., M.S.
Guy's Hospital, London, England

LULU G. GRAVES
135 East Fiftieth Street, New York City

RT. REV. MGR. MAURICE F. GRIFFIN
Cleveland

JOHN R. HOWARD, JR.
Muhlenberg Hospital, Plainfield, N. J.

F. STANLEY HOWE
Orange Memorial Hospital, Orange, N. J.

LEWIS E. JARRETT, M.D.
Hospital Division, Medical College of Virginia, Richmond, Va.

B. C. MACLEAN, M.D.
Strong Memorial Hospital, Rochester, N. Y.

M. HELENA MCMILLAN, R.N.
Presbyterian Hospital, Chicago

JOHN R. MANNIX
University Hospitals, Cleveland

ROBERT E. NEFF
University Hospitals, Iowa City, Iowa

D. L. RICHARDSON, M.D.
Charles V. Chapin Hospital, Providence, R. I.

RALPH B. SEEM, M.D.
New York City

GEORGE D. SHEATS
Baptist Memorial Hospital, Memphis, Tenn.

DONALD C. SMELZER, M.D.
Graduate Hospital of the University of Pennsylvania, Philadelphia

HERMAN SMITH, M.D.
Michael Reese Hospital, Chicago

GEORGE F. STEPHENS, M.D.
Winnipeg General Hospital, Winnipeg, Canada

FRANK J. WALTER
St. Luke's Hospital, Denver

JOSEPH J. WEBER
Vassar Brothers Hospital, Poughkeepsie, N. Y.

LUCIUS R. WILSON, M.D.
John Sealy Hospital, Galveston, Tex.

You Would Expect it to be a Nice Outfit Doctor

"THAT is a nice looking outfit you student nurses wear, Miss Nash. I've often wondered how the girls could all get uniforms that fit so well and look so nice even after they've been worn for a year or two."

"That isn't so surprising, Doctor, when you consider that these outfits were made by the same people that make the operating gown* you are wearing. I overheard the superintendent say only yesterday that she is buying all our hospital garments from Marvin-Neitzel now. Seems that she has found them very economical as well as extremely satisfactory."

"I guess, maybe, you are right, Miss Nash. All the men on the staff like these gowns very much. They wear so much better, too, than the gowns we were using."

* Operating Gown Style 339 priced from $12.50 a dozen.

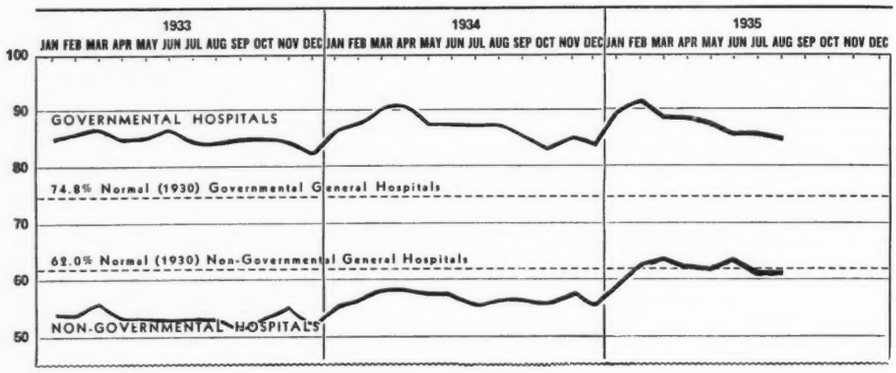
•

Marvin-Neitzel Corporation

"Everything from Cloth for the Hospital and School of Nursing"

Troy, New York

The Hospital Barometer



Occupancy in voluntary hospitals continued in August to hold its 4½ point lead over the corresponding month of 1934. The figure for general hospitals maintained by governments fell slightly, indicating that these institutions are gradually overcoming their excessive crowding.

There were 31 hospital building projects reported from August 26 to September 23, inclusive. Of these 29 reported costs which totaled $3,919,415. One was a $10,000 alteration, eight were new hospitals of which seven had costs of $663,000 and the remaining 22 were additions to hospitals. Of the last group 21 reported costs of $3,246,415. The average cost per project for the entire group was $135,152.

The improvement in business activity, which has been noted during the last two months, continued during August and the first half of September, according to the regular monthly survey of the National Industrial Conference Board. Greater-than-seasonal increases took place in the construction, steel and electric power industries. Machine tool orders, which are often considered a good index of industrial confidence, rose slightly less than the usual seasonal amount during August, but remained more than three times greater than a year ago. A decline in automobile production is attributed to the decision to introduce new models in the fall rather than the spring. This will upset during the next few months comparisons with past years for this industry.

It is interesting to note in the report of the board that common stocks and corporate bonds rose during the first half of September to the highest levels for the year. Stocks reached the highest point since the early autumn of 1931. Measured in monthly averages, the recovery in common stocks from 1932 to the end of August amounted to 24 per cent of the 1929-32 decline.

The general wholesale price index of the *New York Journal of Commerce* increased slightly from August 24 to September 21, going from 80.0 to 81.2. Grain prices advanced sharply, the index going from 85.9 to 92.7. General food prices also advanced rapidly in the first part of the period but since September 7 have declined from 88.6 to 84.8. Textiles increased slightly, fuel remained unchanged and building materials declined slightly in cost. The *Journal* anticipates that the conservative production policies being followed by most cotton mills may bring further advances in cotton goods prices before long. The price index for drugs and fine chemicals of the *Oil Paint and Drug Reporter* advanced slightly during September. The ominous prospect of war in Europe was considered to have been partially influential in certain price rises that have been noted.

Occupancy Figures of Hospitals in Various States and Cities

Type and Place	Census Data on Reporting Hospitals[1]		1934					1935							
	Hospitals	Beds[2]	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.
Nongovernmental															
New York City[3]	68	15,194	62.0	61.0	66.0	68.0	66.0	70.0	72.0	74.0	70.0	75.0	75.0*	75.0*	75.0*
New Jersey	58	9,772	59.0	58.0	60.0	61.0	58.0	62.0	65.0	66.0	65.0	66.0	64.0	62.0	62.0*
Washington, D. C.	9	1,782	59.3	60.7	65.4	65.3	61.8	72.0	71.8	70.5	69.8	68.7	70.6	68.2	62.0
N. and S. Carolina	100	5,861	62.3	60.9	61.1	60.9	56.8	60.6	63.1	64.9	62.3	64.6	66.8	65.7	66.2
New Orleans	7	1,198	52.1	49.5	49.5	47.7	44.9	47.7	49.5	50.1	46.8	50.9	58.3	57.1	58.2
San Francisco	15	2,613	56.9	60.8	64.2	63.2	62.0	65.5	68.2	67.4	69.5	66.4	67.4	62.4	62.4*
St. Paul	6	912	45.7	43.4	39.1	45.8	45.8	41.5	53.6	55.9	52.3	48.8	51.7	46.4	48.3
Chicago	24	6,264	59.3	55.6	56.9	57.9	54.5	57.4	57.3	61.9	58.8	55.9	54.7	54.5	53.9
Cleveland	5	1,001	58.4	56.7	57.8	57.7	56.5	61.9	62.0	62.0	63.6	65.7	63.4	63.2	67.2
Total[4]	292	44,597	57.2	56.3	57.7	58.6	56.3	59.8	62.5	63.6	62.1	62.4	63.5*	61.7*	61.8*
Governmental															
New York City	16	11,615	89.5	88.3	89.4	91.0	92.9	96.7	100.6	103.2	104.6	105.6	100.4	103.6	93.2
New Jersey	6	2,122	80.0	80.0	83.0	81.0	78.0	86.0	86.0	84.0	85.0	84.0	77.0	79.0	79.0*
Washington, D. C.	2	1,316	80.2	81.7	78.1	84.8	77.6	86.6	95.5	76.3	72.7	69.4	67.4	68.4	69.5
N. and S. Carolina	13	1,256	66.9	64.0	67.0	68.3	64.7	65.4	65.7	68.5	65.8	68.6	68.1	68.7	72.3
New Orleans	2	2,227	152.4	148.0	129.3	131.6	130.5	144.9	145.4	130.4	130.8	132.8	138.8	145.1*	146.7*
San Francisco	3	2,255	77.9	74.4	72.7	78.1	74.2	77.4	79.1	77.1	80.3	77.3	72.3	72.0	72.0*
St. Paul	1	1,050	68.0	67.3	66.8	68.5	68.8	74.4	78.7	77.8	75.8	75.2	74.5	67.3	63.4
Chicago	1	3,300	83.7	83.1	84.8	87.0	84.7	89.0	83.4	93.9	84.2	86.0	84.5	83.5	80.4
Total[4]	44	25,141	87.3	85.9	83.9	86.3	83.9	90.1	91.8	88.9	88.7	87.4	85.4	86.0*	84.6*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 45 OCTOBER, 1935 NUMBER 4

Social Consciousness—By-Product of Voluntary Hospitals

By CHARLES H. SCHWEPPE

Vice President, Lee, Higginson Corporation; President, St. Luke's Hospital, Chicago

Take away opportunity and incentives for voluntary social enterprise and social consciousness is diminished among leaders who should have it in greatest measure, the author holds

UNDER the present tax law, gifts or subscriptions to philanthropic and not-for-profit social institutions or organizations, up to 15 per cent of total income, may be deducted from taxable income. The new law only remains unchanged in this regard because Congress voted down the President's suggestions that no deductions be permitted for such subscriptions.

An influence is at work in our government and political agencies to take away eventually all incentive for giving or subscribing funds to social enterprises which represent the independent efforts of thoughtful men and women to meet the social problems of their own community by their own foresight and by means directly under their control.

In addition to the income taxes there is agitation for certain state and inheritance taxes which would again adversely affect the interests of independent social institutions such as universities, hospitals, public health institutions and independent social welfare organizations.

Agitation in this direction will continue and it is not at all unlikely that, little at a time, it will be successful as the various tax laws are modified or changed. Even now there is talk in Washington to the effect that the tax law just passed will be changed at the next session of Congress.

In the controversy that rages over the rate and amount of taxes, the characters and kinds of taxes levied are being given scant consideration. On the other hand, those who are and have been vitally interested in the progress of our social institutions, particularly independent institutions, find reason for grave concern about the nature of taxes which affect those institutions. An obvious question suggests itself. Why reduce the stimulus

to give to independent social institutions? Why do anything which will in effect withdraw from these institutions the funds necessary for their maintenance and operation, and in addition, overwhelm them by setting up government social institutions to compete with them?

The growth and development of independent social institutions in America is one of the phenomena of history. In point of fact, billions have already been invested in these independent institutions. Their service programs have been carefuly mapped out over a period of years and are based on extended experience in practically all fields of social activity. And they themselves, are, in many respects and in many fields, adequate to meet needs.

A Dangerous Tendency

It is perfectly obvious that funds taken from them and paid into tax coffers will set up competing institutions under government and political dominance and control. There is, of course, in every field of social enterprise, a need for some government institutions which will render service to indigents to a greater extent than can the independent institution; nevertheless, the independent institution can generally render a higher quality of service more efficiently. Furthermore if these institutions are swamped huge capital investments will be wasted. Yet it seems apparent that there is a concerted and organized move afoot to transfer gradually all social activity from the independent institutions and organizations to corresponding institutions and organizations operating under political dominance.

No one vitally interested in social enterprise can view this situation with equanimity. In the field of hospitalization for instance, we actually find government hospitals competing with half-filled independent voluntary hospitals of the highest conceivable type and character.

It is hardly necessary to compare the quality and efficiency of service in a large independent hospital with that of a similar government hospital. To begin with, a given fund administered by a board of trustees will, with few exceptions, build a better hospital than can be built for the same fund politically expended. And in the matter of hospital service, the independent hospitals have consistently led the way. Their administrations have, in practically all instances, been better. Their contributions to medical science have been greater and their leadership has always been generally recognized.

Great scientists and professional men do not as readily go into government service as they do into the service of independent institutions. There are several reasons for this, not the least of which is that many times they cannot afford, because of lack of private means, to go into the less remunerative government service. Another reason is that in independent social institutions they know their tenure of office depends more directly upon their ability. It is also a practical fact that politics is not conducive to rigorous research and investigation efforts and frequently does not offer an opportunity to pursue rational and effective work without interruption. No able man wants his work interrupted by political whimsy.

Let us turn to other comparisons between government institutions and our large independently supported and endowed social institutions. As an example, the great endowments and foundations which finance the broadest scientific investigations and developments are all the products of independent social enterprise. The men and methods employed in these foundations do as much or more than any other single force to raise living standards in our society. One must never lose sight of the fact that Pasteur probably did more to sell electric ice boxes than all advertising and sales agencies together have done today. And it is independent social institutions which in the American social scheme back such men today.

If, as we are so frequently urged, we could open our minds to a wholly rational point of view, one might offer some uncomfortable speculations to those who for one reason or another would bring all social enterprise under political control.

At the present time a wealthy man may give $100,000 to a Chicago hospital of greatest scientific eminence and standing and if the subscription of $100,000 does not amount to more than 15 per cent of his personal income he may deduct the subscription from his taxable income. Note carefully that he does not deduct his subscription from his tax. He is only allowed to deduct it from taxable income.

Hasn't He Paid His Share?

Now, let us presume that the amount given to this outstanding hospital represents just the amount of his total tax which would be allocated through government budgets to general hospitalization. The question naturally arises — has he not already paid his share toward the support and maintenance of social enterprise as it is represented in the field of general hospitalization? Why should he then be required to pay an additional sum in tax, almost as large, to general hospitalization provided by government hospitals under political control?

Let us seek a parallel in another field. At the last session of Congress it was generally assumed

that thoughtful and far-sighted employers and employees who have banded together to set up old age security funds in their corporations, should not be required to pay taxes for the maintenance of compulsory old age insurance, governmentally administered, covering the same employees. Why, then, should those who, on their own initiative, support and maintain other social security enterprises equally necessary and useful, not be given at least some similar consideration?

One might speculate further to the conclusion that if there were substantial incentives for the support and maintenance of independent social enterprise, independent social institutions sponsored by individual and group initiative and meeting more fully the need of their separate communities, would replace to considerable extent the mass of social welfare institutions growing up under political dominance. Every man thinking about this question can answer it by telling whether if he had the funds he would prefer to give them to an independent social institution or a similar government institution.

However, I believe we meet a much more fundamental issue in this situation. It is the vogue to criticize leaders in commerce and industry for their lack of social consciousness. With and without reason, they are being accused of being unconcerned about social welfare in the broadest sense of that phrase.

The Need for Social Consciousness

Anyone who has for years taken an active part in the administration, maintenance and operation of, for instance, a hospital has been confronted with this lack of social consciousness. It is not as great as some critics pretend and in some quarters it does not exist at all. Nevertheless, it is to be found and thoughtful persons ask why. As one looks about in the field of social enterprise it becomes apparent that social consciousness among leaders in commerce and industry is very uneven — exists in extremes. Some are unconcerned, but probably no men in the history of the world have had a more profound social consciousness than some of our great American philanthropists.

If we look more closely we find that the commercial or industrial leader who manifests the greatest interest in social welfare is invariably the one who gives large sums to independent social activities.

It is an unbroken rule among those who have experience in financing independent social progress, that a man's active interest and his material resources must go hand in hand if they go into social welfare. A man who is given an opportunity and an incentive to put excess earnings into a good hospital will become interested in public health — one of the four essentials of social welfare. Conversely, when a good independent hospital is given a fair opportunity to cultivate the interests of a man, his excess dollars follow that interest automatically — almost incidentally. He gives time and effort as well as money to that hospital and he brings to its administration and operation an invaluable asset, but the important thing here is that he learns about social needs. Social consciousness is a product of voluntary and independent social enterprise.

A Concrete Example

An example of this worth describing comes to mind. A newspaper man was talking to a trustee of one of our larger Chicago hospitals whom we shall call Mr. Smith. At one place in their discussion the newspaper man asked, "Mr. Smith, what really happens to a man's social consciousness when he becomes a member of your board of trustees?" Mr. Smith did not answer the question directly. He rather indicated that probably nothing in particular happened.

But later in their talk Mr. Smith got to telling about some work he was doing down at the hospital. He first told how he had been making fairly frequent visits to the hospital at most any time of day or night. In visiting with ward patients he had become impressed with the fact that many ward patients could not convalesce properly because of worries and apprehension about their home conditions. "You know," he went on, "most men are behind scratch when they go to a hospital for care. The more serious their illness and the longer they have to stay, the greater are their worries. Their earnings have stopped. Bills pile up. When they do get out of the hospital they may find themselves without a job. So even when we give them the best possible hospital care it is not as effective as it should be. Their proper convalescence is almost always in danger and they are not in a condition to do their best work.

"Well, I started out by getting one man a week a job into which he could step when he was able to go back to work. Now, I'm trying to make it jobs for two men a week. And if I ever get back to the place where I can do it, I'm going to try to establish some kind of an employment bureau for patients who are able to work when they are discharged from our hospital."

As Mr. Smith was telling about this hospital activity of his, his whole manner changed to one of enthusiasm. His face lighted up and it wasn't hard to tell what that work meant to him in terms of social consciousness.

Meanwhile, the newsman's face had brightened,

too. Finally, when Mr. Smith finished his story, the newsman shot a question at him. "Mr. Smith, would you ever have known or become interested in that particular social problem if you hadn't become a trustee of the hospital? And would you ever have done anything about it? Matter of fact, you've answered both those questions, and also my other question, 'What happens to a man who becomes a trustee of a voluntary hospital?' "

Does a man's interest follow his tax paying dollars into some unknown kind of social welfare work done in a remote community under patronage appointment and political dominance? Is his social view expanded as soundly by government institutions in which he has little interest as by independent social institutions in the work of which he takes a vital part? The history of social development in this country would answer both those questions in the negative.

Share the Wealth Not a New Idea

In every direction one finds that the greatest social consciousness has been developed among leaders in commerce and industry by independent social enterprise when it is given a fair chance and when sound incentives for it exist. Sharing of wealth is not a new idea coming out of the minds of politicians. Great American philanthropists have in many instances actually achieved the most constructive form of wealth sharing. Instead of distributing their excess earnings to other individuals and thus not essentially changing the control of wealth, they have redistributed wealth to the society that provided an environment in which they were able to create wealth.

The wealth they have redistributed is the most fundamental wealth in the world — public health, scientific advance, educational advantages, social progress and welfare — much of it wealth which can hardly be destroyed even by society itself. Wealth which does more than anything else to raise living standards.

It should be noted, too, that intelligent philanthropists are coming to understand that their redistribution of wealth is not charity in the little sense of that word. It is but the repayment to society by those unusually privileged to serve society — an absolute essential in a sound economic system which is democratic in form and continually redistributes opportunity and privilege to all. It is a perfectly obvious dollars and cents account.

Take away opportunity and incentives for voluntary social enterprise and social consciousness is diminished among leaders who should have it in greatest measure, and the processes which have produced splendid results in America are completely reversed. No wise and prudent government will do anything to destroy the work already done and the even greater future possibilities of voluntary social enterprise.

Keeping Windows Clean

Window washing is a housekeeping problem of importance in the large hospital. Clean windows have more to do with giving any room a clean appearance than any other single item, in the opinion of Mrs. Georgia Hunt, an executive housekeeper and president of the Chicago Hotel Women's Association. She places clean light bulbs, the "windows" that admit light to rooms at night, in the same class.

"Contract" window washers are not recommended by Mrs. Hunt for either hospital or hotel use, in a discussion of the problem in the *Hotel Monthly*. They are likely to come when they please, instead of on schedule, and when they do come they insist upon doing every room regardless of the wishes of the occupant.

The number of windows that can be washed in a day depends upon the kind of window, kind of sill and architectural factors. In a normal building, where there is ample window sill to stand on, and the usual hooks for attaching belts, with double hung windows, a washer should complete somewhere between forty-five and sixty windows a day. This range is allowed to compensate for certain buildings having several windows per room as against those having only one per room. Obviously, it will take longer if it is necessary to enter and leave rooms after washing only one window.

Window washing and cleaning light bulbs and chandeliers should be done by the same person or persons, once they have been taught how to do the work properly, Mrs. Hunt believes. In buildings large enough to employ full-time washers, of course, the problem of training is settled. But in buildings where one man working a week steadily can do all the windows, it will be found better to have the same man do the job always. He will be quicker, better and will make less muss.

To conserve the time of the window washer, a schedule should be made out in advance indicating the rooms to be serviced. Rooms should be in the same block so that time is not lost in using the elevator or in going from one part of the building to another. Some rooms in such a block will, of course, not be available when he comes; these may be taken care of the first thing the following day.

A standard record book, such as is designed for linen room control, may be used to keep records of the windows washed, Mrs. Hunt observes. At the end of each day the window washer turns in a report of the windows he washed that day, and from this report the information should be posted into the master control book. The day of the month on which the window was washed is inserted in the proper month column, and on the line carrying the room number. Should the washer repeat on any rooms before the regular schedule, the book will show up the matter promptly. Likewise if a room is skipped either in error or purposely, it can be located by referring to the record book.

For the Price of a Paper a Day—

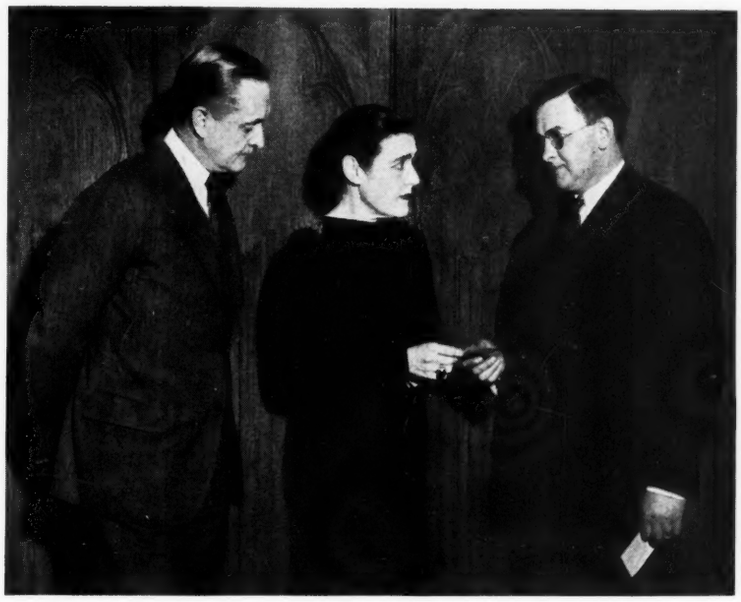
By MAXWELL HAHN

**Director of Public Education,
Associated Hospital Service of New York**

The wage earner can budget the cost of his hospital care

"NEWS of New York's 3-cents-a-day plan for hospital care has come out here by radio, press and motion picture. It has been a great help to all of us to have the largest city formally working out a plan."

Messages such as this one from the executive secretary of a group hospitalization project well established in the Northwest gives us a great deal of satisfaction. It is encouraging to know that in producing results in the metropolitan area in excess of our anticipations we are contributing to the success of other group hospitalization projects.



Fannie Hurst, popular novelist, was the first subscriber to the three-cent plan. Miss Hurst is shown receiving an application card from Frank Van Dyk, executive director of the service.

When the Associated Hospital Service of New York was organized it was estimated that 25,000 members the first year would be a satisfactory achievement. At the present rate of enrollment we shall have 25,000 members before the hospital service plan has been in operation six months. In fact, the ten-thousandth member was enrolled when the plan had just completed two months of operation.

Occasionally a letter comes from an individual who would like to manage a hospital service plan in some city which does not have such a plan now. The letter always contains this query, "What steps are to be taken in starting a 3-cents-a-day plan for hospital care?"

We are glad to furnish as much information as we can in the available time, but our answer uniformily contains this advice, "We recommend that an experienced individual be obtained to start the 3-cent plan."

In New York we were fortunate in obtaining the services of Frank Van Dyk as executive director. His experience in Newark and his broad knowledge of hospital problems have proved invaluable in establishing the hospital service plan.

For six or eight weeks before Mr. Van Dyk could leave Newark to open the New York plan to public enrollment we concentrated upon a program of public education. There had been occasional stories during the preceding two years as Homer Wickenden, general director of the United Hospital Fund, and Dr. S. S. Goldwater's committee had advanced the project through the essential preliminary steps, adhering to the group hospitalization recommendations made in March, 1933, by the special committee appointed by the Medical Society of the State of New York.

The words "group hospitalization" meant nothing to the public when the campaign of public education was laid out this spring. Nor did the term mean much to most hospital trustees, it soon became apparent.

The first problem, then, defined itself as finding an understandable label for group hospitalization. We had not found it when the first news story went out for release Monday, March 11. To help the reader visualize the low cost, David H. McAlpin Pyle, president of the United Hospital

Fund, was quoted in the story as saying, "The new service will enable salaried persons and wage earners to budget the expense of hospital care for approximately the cost of a newspaper a day." This was based on our rate of 90 cents a month by pay roll deduction.

The *New York Times* developed this idea with the headline,

THREE CENTS A DAY
FOR HOSPITAL CARE

The Associated Press flashed the story of three cents a day for hospital care across the continent, radio commentators microphoned it to their listeners throughout the United States and Canada, and Paramount News Reel eagerly put the story on movie screens from coast to coast.

The amazing part of all this to us who were closest to it was that group hospitalization had already passed its fifth birthday in the United States. It was not new. It had had a chance to grow through its own merit and it was doing so. Nevertheless one wondered whether its English ancestors were not eating more spinach or drinking more orange juice, for the English associations had enrolled over four million members.

Name Makes a Hit

We took the cue from the *New York Times* and christened group hospitalization in New York the "three-cents-a-day plan for hospital care." The catchwords, "three cents a day for hospital care" are easy for the public to understand. They meet the standards laid down by Knight Dunlap, psychologist, in his statement that "Positive assertions, to be efficacious, must be couched in simple and familiar language, so that the persons addressed may think the idea without difficulty." Edgar Stern-Rubarth had the same thing in mind when he said that "It seems that the overpowering of the modern human mind by too many impressions, seen and heard, calls for the utmost condensation of everything to which attention is to be called."

When the hospital contracts were sent out for acceptance by hospital boards, we got our first warning that group hospitalization was a baffling term to many board members. Some of them confused it with a scheme to insure hospital employees under state compensation law requirements.

Our symbol for group hospitalization, "three cents a day for hospital care," produced results too fast. Our temporary headquarters were flooded with requests for an opportunity to enroll and, despite the fact that the Associated Hospital Service was not yet listed in the telephone book, hundreds of persons were sufficiently interested to get the number from "information."

The initial response confirmed our original conviction that group hospitalization should be popular in the United States if it were put into words that the ten-cent store salesgirl, the cloak and suit worker, and the others with small income and limited education could understand.

Among our policies are these:

1. All publicity must be ethical. We conform to the code of ethics for hospital publicity adopted by the American Hospital Association.
2. This hospital plan is a community service.
3. All publicity must be dignified, constructive and purposeful.
4. We stress the idea that the hospital service is mutually helpful to the public, to the hospital and to the medical profession.
5. All queries by reporters, magazine writers and editors are answered promptly.
6. Our address, 370 Lexington Avenue, is mentioned in every news release. We do this so that anyone who has the impulse to communicate with us can do so with minimum effort on his part.

For 3¢ a day
You get Hospital Service
WHEN YOU NEED IT
125 HOSPITALS OFFER THIS TO YOU
Join in groups
of 10 or more
ASSOCIATED HOSPITAL SERVICE OF NEW YORK
NON-PROFIT CORPORATION
370 LEXINGTON AVE. NEW YORK, N.Y. CALEDONIA 5-7150

One of the posters used in giving publicity to the plan.

The publicity gained momentum rapidly. Each organization step was reported to the papers. When fifty-two hospitals had signed contracts as participating members we released their names to

the metropolitan papers. The *New York Herald Tribune* played this as a top story on page one, once more flooding us with inquiries. The *Times* sent a man to our office to get material for an editorial. All of the metropolitan papers wrote one or more editorials. Through this preliminary publicity so many requests were received that there has been no need to seek interviews with employee groups. The employee groups themselves have originated the requests for an opportunity to become members of the three-cent plan.

When we started to enroll members, Fannie Hurst was enrolled as the first member. I believe that Miss Hurst was an excellent choice. We tend to accept as valid those ideas which our group leaders approve and adopt. To thousands of New Yorkers, both men and women, Miss Hurst is a guide who may be trusted implicitly. She has a tremendous following of working girls—one of the largest groups which should find the hospital service plan helpful.

Miss Hurst familiarized herself carefully with the full significance of group hospitalization before she lent her prestige to the project.

The *Chattanooga Times*, concluding an editorial on the 3-cents-a-day plan, wrote: "And lest any should think that subscription to such a plan would be beneath their dignity, let it be said that Fannie Hurst, noted novelist, who is well known to readers of the *Chattanooga Times*, was the first to join the group of employees in her apartment building in signing up for the New York service."

Dr. Walter Granger, noted scientist explorer who was associated with Roy Chapman Andrews in the Gobi Desert expedition which discovered the first dinosaur eggs, is the ten-thousandth member. Dr. Granger was enrolled with one hundred employees of the American Museum of Natural History.

There were stories of the first member hospitalized. This honor fell to a sales girl in the cloak and suit department of a department store.

Our first Bronx patient, the first Queens patient, the first Westchester patient, and the first New Jersey patient were the basis of stories of interest to local communities. No patient's name is published without his written consent, given on a form which is signed by two witnesses.

The registered nurse who runs a column in the *Brooklyn Eagle* described the plan one day. Mr. Fixit of the *Long Island Press* asked for material for his column. Feature writers have described the plan's operation.

Our radio programs have developed broad in-

Among groups who enrolled promptly are armored car men who transport pay rolls for U. S. Trucking Corporation.

terest in the plan. Undoubtedly our best program was a symposium broadcast over WOR Easter Sunday evening.

Dr. Samuel J. Kopetzky, editor of *New York Medical Week,* took as his subject, "The Doctor Considers the Plan." Dr. John H. Finley, associate editor of the *New York Times,* discussed the hospital service plan from the citizen's point of view. William C. Breed, Jr., of Breed, Abbott and Morgan, counsel for the Associated Hospital Service, described the legal steps which safeguard the public. David H. McAlpin Pyle, president of the United Hospital Fund, spoke on the subject, "United Hospital Fund Sponsors 3-Cent Plan."

At the world première of Colleen Moore's doll house, which was exhibited in New York for the benefit of the United Hospital Fund, Miss Moore, Mr. Pyle, Mrs. James Roosevelt, mother of the President, and former Governor Alfred E. Smith, each broadcast. Governor Smith took occasion to say that the 3-cent plan is timely and to commend it to his large following.

Another radio tie-in was with Martha Manning, who has a large audience of housewives for her morning program. Mr. Van Dyk's brief exposition of the plan over the air resulted in many requests for information.

We send every news release which may have air potentialities to the radio commentators. Lowell Thomas, Edwin C. Hill, Boake Carter, Harlan Eugene Reed are among those who receive this material and draw upon it. Trans-Radio Press also is interested in our activities.

Thousands of inquiries have come from the leaflets which the Manufacturers' Trust Company, the National City Bank of New York, the Marine Midland Trust Company and the New York Trust Company have enclosed with their monthly statements to depositors.

Permission to enclose the leaflets with the canceled checks was obtained through the following individually typed letter to bank presidents, signed by Mr. Pyle, as vice chairman of the executive committee of the Associated Hospital Service:

"Within the next week the three-cents-a-day plan for group hospital care, which is being introduced by the Associated Hospital Service, sponsored by the United Hospital Fund, will be in operation.

"There is an opportunity for your bank, at no cost to itself and without inconvenience, to assist further this great constructive step toward meeting some of the high costs of illness. We would appreciate it if your bank would consent to insert the attached leaflet in your next mailing of monthly statements to your depositors. Many of them will be interested in obtaining membership in the hospital service for themselves and many others will wish to call the plan to the attention of their employees.

"If you will be good enough to notify me in writing as to how many leaflets you could use and when you want them, we shall comply with your request promptly.

"With much appreciation for your helpfulness in this nonprofit project for the good of the whole community."

We faced one problem when a bank called us at noon to say that it would enclose the leaflets if we would distribute 100,000 statements among its fifty-five branches from Coney Island to the Bronx by noon of the next day.

We had less than 20,000 leaflets available. They had been printed in two colors, requiring a double press job. And the NRA still was in operation! The exceptionally capable printer who prints our leaflet met the situation and every bank received its leaflets on schedule.

Catgut Waste Called Appalling

The appalling waste of catgut in surgical operations is the subject of an editorial in the *Pennsylvania Medical Journal,* which finds a surprising lack of thought given by the surgeon and his assistants to this form of operating room technique. The hospital, of course, bears the loss.

"We should worry. The patient pays an operating room fee." This typical response is refuted by the medical journal, which points out that only a percentage of patients pay an operating room fee and even if all did it would be no excuse for an unnecessary waste of supplies.

The editorial says, in part:

"Technique comes naturally to some individuals, while others acquire it only after much drilling; then there are those who continue through life with a slip-shod way of doing things. There are entirely too many associated with surgery who will not show any disposition to conserve in the use of catgut or other supplies — reckless extravagance. It is most unfortunate that assistants very often follow the bad habits of their chief.

"The individual using the catgut is primarily responsible; secondly, the nurse at the instrument table. The nurse too frequently opens more tubes of catgut than will be used instead of watching the operator closely and anticipating, when possible, his next need. With a trained personnel there should be a negligible amount of waste material. When there is not a trained operating team in action, the individual doing the operating should anticipate his need by asking for the catgut he will use next, specifying the size and whether plain or chromic.

"Catgut is frequently wasted by that group of surgeons who use a half a strand for a single tie, whatever and wherever it may be, or even a third of a strand. Such woeful waste is entirely unnecessary and the procedure adds nothing of practical value to the surgical technique."

Planning the Radiologic Department*

By R. A. RENDICH, M.D. and C. B. BRAESTRUP, P.E.
General Director of Radiology and X-Ray Physicist, Respectively, Department of Hospitals, City of New York

RADIOLOGY has shown such rapid progress during the past years that increasing demands are made upon equipment, space and other facilities. Both in the diagnostic and therapeutic application of roentgen rays, the tendency is toward x-ray generators of higher and higher output. To accommodate this modern type of equipment and to provide space for the adjunct activities, a layout considerably different from that of the older x-ray departments is required.

The aim of this paper, therefore, is to present the requirements of a complete, modern x-ray department for various sized hospitals, with due consideration given to a safe, efficient and economical layout.

Location and Space Required

The radiologic department should be readily accessible to clinic patients as well as to those who are hospitalized. The rooms must be at, or preferably above, ground level, in order to ensure maximum air and light and to reduce humidity to a minimum.

Outside walls are highly desirable, not only on account of the natural light and ventilation afforded, but also because of the great saving in x-ray protective materials which otherwise must be incorporated in the walls for the absorption of the stray rays.

The exact size of the radiologic department will depend upon a number of conditions, the most important of which are: type of hospital, its bed capacity, the size of the dispensary service and possible future demands.

In Table I is given the approximate floor space required by the radiologic department of different sized general hospitals, assuming that the dispensary demands, approximately, are 33 per cent of the total radiologic requests. Hospitals caring primarily for private patients, as well as institutions for teaching and research, will require considerably more space than is indicated. Hospitals of the custodial type may get along with less.

The ceiling height should not be less than 11 feet in order to provide ample clearance from the high tension aerial system. If complete shockproof equipment is used, this requirement may not be absolutely necessary, as all exposed high tension conductors are eliminated.

It is important that no pipes or beams shall protrude or be suspended from the ceiling.

Well lighted and ventilated rooms are essential, whether used as light or dark rooms, and all should have proper exhaust systems on account of the obnoxious gases created during the generation of x-rays. Special ventilation is particularly necessary in fluoroscopic and film processing rooms as these must be used with windows closed.

Radiators should be recessed in all rooms, and doors should be placed so as to obtain a maximum amount of wall space, a necessity for the proper placement of x-ray apparatus.

The radiators should have hand operated, independent controls as well as automatic thermostatic controls.

The finished floor needs a covering of heavy battleship linoleum or rubber tile.

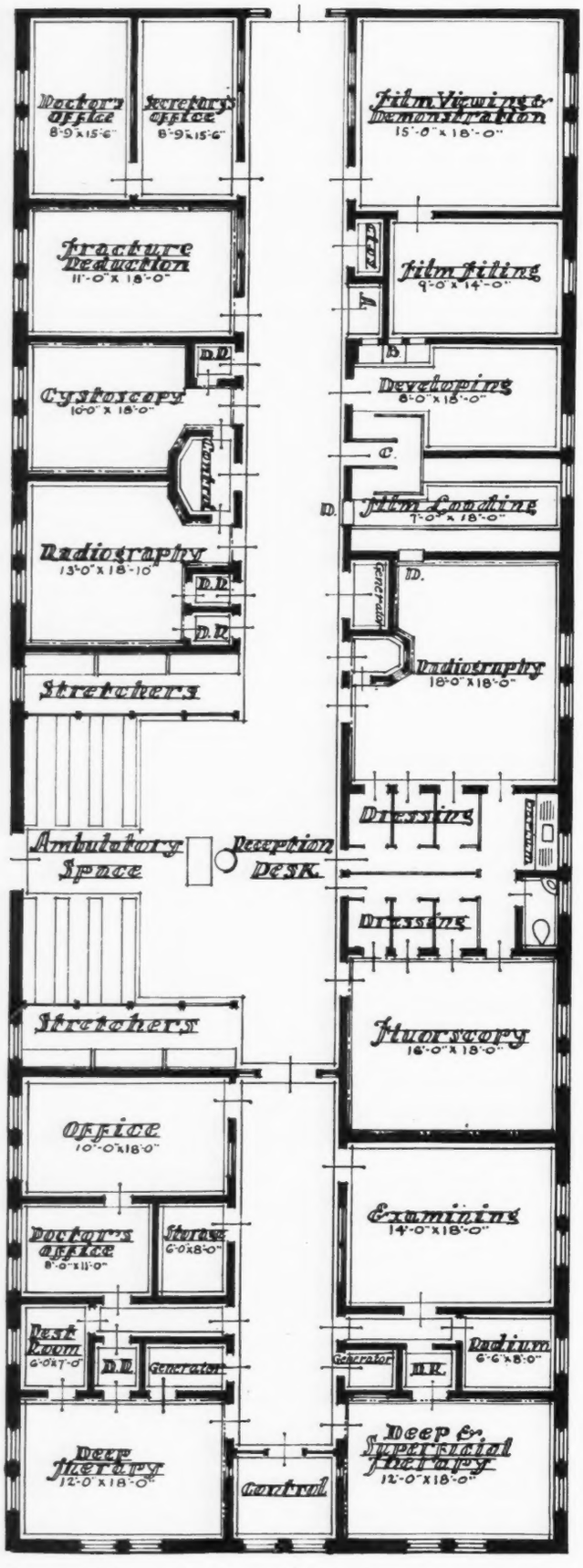
All stretcher entrance doors should be at least 36 inches wide. Other doors should have sufficient width to allow replacement of equipment. Small peeps should be provided in doors between the radiologic rooms and the halls.

Color of Walls Important

The color of the walls should be as cheerful as possible and yet of a shade that will not show the accumulation of dust inherently associated with the electrostatic fields caused by nonshielded aerials. For lightproof rooms special paints prepared for this purpose should be used. Likewise, in the film viewing room it is desirable that the ceiling and walls have a surface that will reflect a minimum amount of light. Windows should be darkened by means of sliding shutters or opaque roller shades sliding in deep slots.

It has proved most unwise for building contractors to construct special appliances such as developing tanks, illuminating cabinets and pass boxes. Proper construction necessitates special specifications based upon long experience in this field. The standard products may better be procured from the specialty manufacturers.

*From the Department of Hospitals, City of New York, S. S. Goldwater, M.D., commissioner.



Suggested layout for the radiologic department of a 500-bed hospital. In this layout it has been assumed that doctors' and employees' coat rooms are outside of the department, as are also additional toilets.

The radiologic department is usually divided into diagnostic and therapeutic divisions, frequently with a common waiting room; in each division it is desirable to have the examining and treatment rooms grouped together and accessible to the waiting room. In the diagnostic division it is best to locate the offices and viewing room so as to avoid interference by patients.

Special requirements for the various rooms are listed as follows:

Fluoroscopic Room

Use: for the direct visualization of the organs of the body with the aid of a fluoroscopic screen. All natural and artificial light must be excluded during this examination.

Location: near dressing, barium and waiting rooms. Adjacent to this room should be a toilet for the exclusive use of the patients being examined. The room should be provided with lightproof shutters or shades for the window. Doors should also be lightproof. One window is sufficient, but ample artificial ventilation is essential. Complete air conditioning should be provided in institutions in the E to G groups (800 beds and over).

Barium Mixing Room

Use: for the preparation of the barium and other opaque mixtures used in roentgenologic examinations.

Location: adjacent to fluoroscopic room. It should be provided with a plaster sink, working table and necessary shelves and cabinets.

Radiographic Room

Use: for making x-ray exposures of the human body.

Location: close to waiting, processing and dressing rooms. The main radiographic room should communicate with the fluoroscopic room through a light lock.

The layout should permit easy access with a stretcher from the corridor. An arrangement usually convenient is to have the control booth and machine room placed in the corners of the radiographic room on each side of the main entrance door to the hall. When this layout cannot be applied, the arrangement shown in the accompanying layout for a 500-bed hospital may be utilized. Proper consideration should be given to the efficient distribution and collection of unexposed and exposed films. Pass boxes should be located close to the control booth in the wall to the corridor or to the processing room. In the latter case a pass box of the lightproof type is required; by using a two-compartment type (for exposed and unexposed films) with the film parallel to the wall, a minimum protrusion is obtained.

Loading Room

Use: for loading and unloading the films in holders and cassettes.

Location: next to the developing room and near the radiographic rooms. For large institutions small additional rooms should be located at convenient points for bedside work. The loading room should be lightproof but with ample artificial ventilation and if possible natural light. Double lightproof pass boxes should be provided in the wall between this room and the corridor (or radiographic room, in case of smaller institutions). The work benches of this room should be linoleum covered, with a slight tilt toward the wall to prevent accidental sliding of cassettes stacked against the wall. Beneath the work bench should

be provided a sliding lightproof drawer in which the exposed films removed from the cassettes may be placed. This drawer passes from the loading room to the processing room and may be drawn to the latter when it contains films for development.

Processing Room

Use: for the development of the exposed films.

Location: adjacent or accessible to the radiographic rooms, near the loading and drying rooms. The processing room must be provided with plumbing facilities so as to ensure an ample supply of hot and cold water, as well as drainage to the developing tanks and the sink of the slop type. If a special refrigerating system is not incorporated with the developing tank, it becomes necessary to provide a connection with the central water cooling system. Tanks and sinks need to be of noncorrosive metal.

This room should be lightproof, but with a window to allow ventilation and natural light when the room is not in use. In hospitals of the C to G groups (300 beds and over) complete air conditioning should be provided. A maze or a light lock serves as an entrance to this room. Also, a lightproof pass drawer for the passage of exposed films from the loading rooms is necessary as was described under loading room requirements.

Drying Room

Use: for the accommodation of film driers in which processed films are dried. A special drying room is required for larger institutions only (E to G groups).

Location: next to the developing room and the room where films are assorted (filing or viewing room). Ducts should be provided for the exhaust air from the driers; these should be mounted on a watertight base with drainage. The driers are to be of the two-door type, placed in the walls between the developing room and the room where the films are assorted.

Viewing Room

Use: for the examination of the finished films, in viewing cabinets and stereoscopes.

Location: near the office and dark (or drying) room and next to the film filing room. The viewing cabinets should preferably be flush with the wall. Lightproof shades should be provided for the windows.

Fracture Reduction Room

Use: for the reduction of fractures and dislocations and other special procedures during which the direct visualization of the anatomic part on the fluoroscopic screen is indicated.

Location: away from the waiting room, near the stretcher patient entrance. It should be lightproof and air conditioned and should be provided with a sink with a plaster trap.

Cystoscopic Rooms

Use: for cystoscopic roentgen examinations.

Location: convenient for stretcher patients; away from the waiting room. These rooms should be treated in general as radiographic rooms. A machine room, however, is unnecessary, since the transformer used for urologic purposes may be of smaller capacity and therefore mounted above the control booth as suggested in the description of the machine room. This room, in addition, should have a sink, electric sterilizer and instrument cabinet. To ensure better radiologic supervision and economy, it is desirable that this room be part of the x-ray department.

Offices

No special specifications are required for the offices, except that there should be in each of the doctors' offices an illuminating cabinet and outlets for a stereoscope. Window shades such as are used in the film viewing room should be available.

Low Voltage Therapy Room

Use: for the application of roentgen rays in the treatment of the skin and superficial lesions.

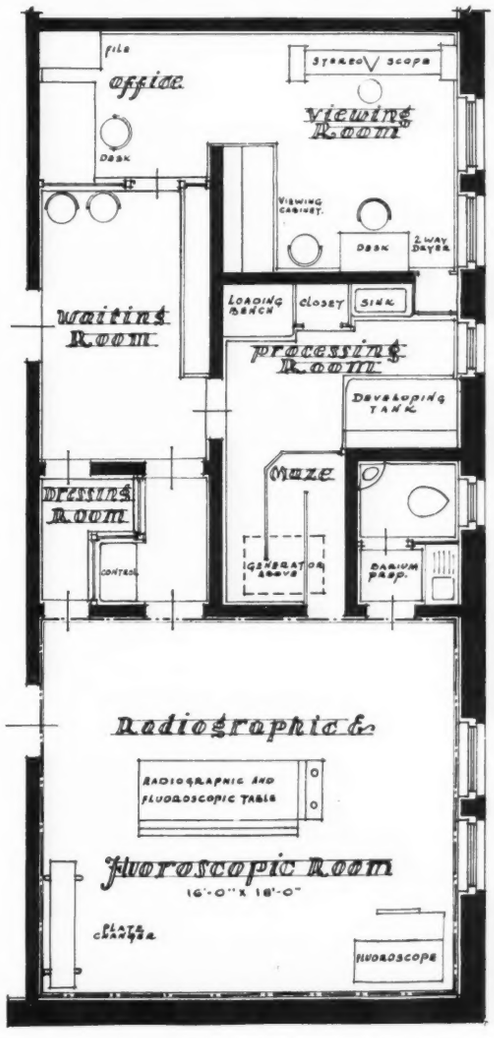
Location: close to or in the proximity of the other x-ray treatment rooms.

High Voltage Therapy Room

Use: for the application of the roentgen rays in the treatment of conditions where high voltage (200 kv. and over) x-ray therapy is indicated.

Location: close to or in the proximity of the other x-ray therapy rooms, with ready access to the corridor, to permit the passage of stretcher cases into the room.

The ceiling height should preferably be not less than 12 feet. Outside walls to reduce lead protection and assure natural light and ventilation are particularly desirable for this room. When voltages much above 200 kv. are contemplated, the layout of the therapy and generator rooms must be arranged to accommodate the particular type of



Suggested layout of the radiologic department of a seventy-five-bed hospital.

equipment to be used. The space requirements differ with the method used for the production of the x-rays.

Radium Room

Use: for the preparation and disassembling of radium applicators and for the storage of radium.

Location: near the examining room but removed from offices and other rooms continuously occupied by radiologic staff.

The room should be provided with a sink and a laboratory bench, gas and electric outlets. No lead lining is needed in the walls to protect against radium rays, as the element is stored in a safe with lead containers and is prepared behind a heavily leaded screen. The floor must be reenforced to take care of this extra weight.

Generator Rooms

Use: to accommodate the high tension transformer, rectification system and accessory equipment for the production of the high voltage required in the operation of the x-ray tube.

Location: adjacent to the x-ray room or rooms it supplies with high tension; also close to the control room, to allow the operator to observe the equipment during operation.

To save valuable floor space, radiographic generators may be placed on platforms 6½ feet above floor level and the space beneath closeted in for use as a bedside unit storage space, dressing booths or supply closets. Whenever possible, separate machine rooms should be provided for each generator, to permit repair and inspection without shutting down more than one piece of equipment. The door should be of ample size (2½ feet in width is usually sufficient) and located so as to provide ready access to all parts of the apparatus that may require repair or replacement. The door should lead to the hall whenever possible. The side facing the control booth should be provided with a large observation window, and the wall leading to the radiographic or therapy room should terminate at least 2½ feet below the ceiling for the transmission of high tension current and for the ventilation of the generating apparatus. A constant moderate temperature and humidity are desirable throughout the year.

Control Room

Use: for the accommodation of the control stand and the operator of the x-ray machine.

Location: for radiography, this room can be arranged as a booth in the radiographic room, eliminating the door, provided there is sufficient extension of the protective wall and rayproof tubes are used.

The control room should be of ample size to permit the convenient use of the control stand. The walls should be lead lined as indicated under protection against radiation, and should also be provided with one or more lead glass windows. These windows should be arranged to permit clear vision of the patient and aerial meters from the operator's position in front of the control stand. Double mirrors may be used to facilitate observation of meters. When the control room is separate from the x-ray room, provision must be made for voice transmission without passage of stray radiation. This may be accomplished by using a special window frame designed for this purpose. It is not recommended, however, that overlapping lead glass be used as it interferes with the vision.

For therapy, it is desirable that the control room be completely separate from the treatment room, and the passage should be closed by means of a door, during operation. When possible, the therapy control rooms should have outside windows, to ensure natural light and ventilation for the operator during the operation of the equipment. The control room should, whenever practical, have direct communication with the hall. At each control should be mounted a bulletin board for technique charts.

Dressing Rooms

Use: for disrobing patients prior to examination.

Location: adjacent and readily accessible to the rooms which they serve. It is desirable that the patient to be examined or treated pass directly from the dressing room to the radiologic room, and leave directly to the hall.

For purposes of ventilation, the walls should, when feasible, be only high enough to ensure privacy. When practical the doors should be three-quarter size. Where dressing rooms connect directly with the fluoroscopic rooms, complete lightproofing and ample artificial ventilation should be provided. The locking system of the dressing rooms should be so arranged as to ensure privacy to the patient and at the same time to prevent the patient from entering the radiologic room until the operator is ready.

Toilets

Use: for patients after the administration of opaque enemas.

Location: adjacent to the fluoroscopic room. In addition to this toilet others should be available.

Light Lock, Maze or Revolving Door

Use: for passage between light and dark rooms (fluoroscopic, loading or processing room) without permitting the entrance of light.

Location: as previously indicated.

The light lock should have two lightproof doors with locks, so arranged that only one can be opened at a time. If the light lock is serving also as a dressing room, it should be provided with a light which is turned off automatically when the door to the dark room is opened.

The maze should have a width of from 22 to 24 inches and should be so arranged that the light would have to be doubly reflected by the walls of the maze before reaching the dark room. Sheet metal is best used in the construction of the maze, on account of the saving in space. The maze should be painted with a nonreflecting coating and need be only 7 feet high. The space above may in certain cases be used advantageously as storage space or as a machine room where small equipments are used.

When the maze is of the single U type, the overlap should be at least two times the width of the passage. If it is of the double U type, the overlap need be only equal to the width. In addition to the maze, it is necessary to have an emergency exit to allow for the passage of the heavy equipment of the dark room. This may be either a separate door or a removable portion of the maze partition. When it is desirable to be able to lock the dark room outside working hours, the maze should be provided with a door. This door should be so placed that it can be conveniently left open during working hours.

The revolving door should be of the three-leaf type and should be absolutely lightproof. This type is not particularly recommended as it usually has a great deal of friction and occupies almost as much space as the maze or the light lock.

Electrical Power Supply and Wiring

It is desirable to use AC as power supply for the x-ray department, as otherwise rotary converters or motor generators would be required to

change the direct current into alternating, which is the type of current used by the x-ray generator.

The main consideration in the calculation of the power feeders is the reduction of any line fluctuation to a minimum; otherwise it is impossible to obtain consistent radiation output, which is essential to secure satisfactory diagnostic and therapeutic results. Even the smallest fluctuation in line voltage may cause considerable variation in the x-ray tube current and therefore in the intensity of the x-ray beam.

X-ray generators may be divided into three groups: (1) single phase generators, (2) three-phase generators and (3) condenser discharge machines.

TABLE I—FLOOR SPACE REQUIREMENTS OF RADIOLOGIC DEPARTMENT IN HOSPITALS OF VARIOUS SIZES

Classification	*A*	*B*	*C*	*D*	*E*	*F*	*G*
Hospital bed capacity	75	150	300	500	800	1,200	1,800
Est. films per day	17	34	67	100	168	240	360
Radiologic floor space (excluding halls, etc.)	590	1,050	1,880	3,940	4,745	6,090	7,550 sq. ft.
1. Fluoroscopic room	...	...	200	300	300	300	350
2. Fluoroscopic room (special)	...	100	...	...	...	...	...
3. Barium mixing room	...	35	60	80	80	80	100
4. Radiographic room	...	...	...	200	...	200	2@200
5. Radiographic room	...	250	250	...	250	...	...
6. Radiographic room	...	...	...	...	...	300	300
7. Radiographic room	...	...	...	300	300	300	300
8. Loading room	50	60	60	100	125	150	160
9. Processing room					125	150	160
10. Drying room			75	125	75	100	125
11. Filing Room[2]	125[1]	100	200	120	150	250	300
12. Viewing room[3]							
				200	250	300	400
13. Fracture reduction room	...	...	...	225	225	350	350
14. Radiogr. and fluor. room	300	...	...	...	...	...	...
15. Cystoscopic room	...	...	...	150	200	2@200	3@200
16. Dressing room	15	2@15	4@15	9@15	10@15	12@15	15@15
17. Stretcher space	...	...	30	90	90	120	150
18. Waiting room	60	75	150	250	400	600	700
19. Stenographers' office	...	60	100	125	150	200	1@100 1@200
20. Roentgenologist office	...	75	100	125	150	175	175
21. Asst. roentgn. office	...	...	...	...	125	125	2@125
22. Storage room	15	25	40	60	80	100	120
23. Portable units' space	25	25	25	2@25	2@25	3@25	3@35
24. Low voltage superficial therapy	...	...	...	...	150	150	2@150
25. Low and high voltage therapy	...	...	250	250	250	250	250
26. High voltage therapy with tube cooling system	...	...	...	275	275	275	275
27. High voltage therapy (air cooled)	...	200	...	...	...	...	...
28. Radium room	...	...	...	50	75	100	125
29. Examining room	...	...	150	250	200	225	250
30. Waiting space	...	...	100	175	200	250	250
31. Office (therapy)	...	...	...	175	175	2@100	1@150 1@100
32. Rad. therapist office	...	...	...	100	100	125	125
33. Dressing rooms (therapy)	...	15	2@15	2@15	3@15	4@15	4@15
34. Physical laboratory	...	...	...	...	...	...	125
Total square feet	590	1,050	1,880	3,940	4,745	6,090	7,550

[1]Includes stenographers' office; [2]current film and paper files only; [3]additional floor space required where viewing room is to be used also for demonstrating purposes. Space for generator and control room included in space allotted to radiographic and therapy rooms. Therapeutic space requirements will depend more upon the type of hospital than upon its size.

The single phase x-ray machine is the oldest and the most common type of the three as single phase current is more widely available. The second group is used when high output is wanted without causing too great a line disturbance. In the third type, condensers are charged at a low rate over a time of a fraction of a minute and are discharged through the x-ray tube in a fraction of a second. This type is used especially in cases where only limited power is available.

The decision as to the proper size of wires necessitates consideration of the time of exposure. In radiographic work, the duration may be as short as 1/120th of a second, while in therapy the exposure may continue from a few minutes to an hour.

It may be possible, therefore, to group radiographic machines together on the same electrical power phase with little likelihood of interference, assuming ample size feeders.

In Table II is shown the size of feeders required for different machines of the single phase type. When three-phase generators are planned, the size of wires can be correspondingly reduced.

A separate x-ray power panel should be provided for the department and preferably located in the main corridor of the x-ray division.

Individual switches should be provided for each generator, making it possible to disconnect equipment undergoing repair or temporarily put out of use. Each generator should be provided, also, with an externally operated safety switch reset in the wall and located within reach of the operator when standing at the control boards. From the load side of this switch, conduit and wires should be provided to the generator room.

Another conduit (without wires) should run from the generator room to the control room, to accommodate the x-ray manufacturers' "control to transformer cable."

The modern type of x-ray equipment requires a number of auxiliary circuits, to the control room from Bucky apparatus, plate changer, fluoroscopes, tube stands and for future requirements. Whenever possible, these should be foreseen, and it is advisable to provide an ample number of these circuits and have all of them, with timer switches, terminate in a box at the control board. Each should be properly labeled. Such an arrangement obviates the careless and dangerous practice of loose wires and push buttons.

The lighting of the x-ray department should be given careful consideration. If possible, the fixtures should be of the concealed type, to ensure ample clearance to the high tension conductors.

TABLE II—MAJOR EQUIPMENT REQUIRED

	Type of Room	Major Equipment	Generator: Rating in ma. at 100 kv.	Generator: Min. Floor Space	Elect. Data: Line Current at 220 V. Amp.	Elect. Data: Size[3] Wires	Lead Protection: Thickness in Inches: Floor	Walls	Ceilings
4	Radiographic	Table, tube stand or special equipment	200	3x4	100	#00	1/16[1]	1/16[2]	
5	Radiographic	Table, tube stand and plate ch.	800	4x5	300	350,000 cm.	1/16	1/8[2]	
6	Radiographic	Table, tube stand and vert. Bucky	800	4x5	300	350,000 cm.	1/16	1/8[2]	
7	Radiographic	Table, tube stand and vert. Bucky + plate changer	800	4x5	300	350,000 cm.	1/16	1/8[2]	
15	Cystoscopic	Cystoscopic table, sterilizer and inst. chest	80	1½x2 on shelf	45	#3		1/16	
13	Fracture reduction room	Fracture table	30		15	#8		1/16	
14	Radiographic and fluor.	Rad. and fluor. table, vert. fluor., and plate ch.	200	3x4	100	#00	1/16[1]	1/16	
2	Fluoroscopic	Vert. fluoroscope	80	2x2½ on shelf	45	#3		1/16	
1	Fluoroscopic	Vert. fluoroscope and hor. fluor.	80	2x2½ on shelf	45	#3		1/16	
24	Low voltage (superficial) Therapy	Table and tube stand	125 kv. 6 ma.	3x4	25	#5	1/16	1/8	
25	Low and high voltage therapy	Table and 2 tube stands	200 kv. 30 ma.	4x6	55	#2	1/8	1/8	1/16
26	High voltage therapy	Table and tube stand	200 kv. 30 ma.	5x6	55	#2	1/8	1/8	1/16
27	High voltage therapy	Table and tube stand	200 kv. 10 ma.	4x6	30	#5	1/8	1/8	

[1] 1/16 lead 3 feet by 8 feet under table in the floor; [2] 7 feet high; [3] assuming 100 feet to power panel and a maximum permissible voltage drop of 1 per cent. Rayproof tubes have been assumed and therapy tables with a sheet of 1/8-inch lead below table top.

Direct illumination should be provided for the meters. This can best be accomplished by floodlights placed directly above the operators' window. They are connected so that the light is automatically on when the main switch of the x-ray machine is on.

All modern hospitals use mobile x-ray units for x-ray exposures at the bedside of the patient; outlets for 110-volt or preferably 220-volt AC should be provided in each ward and private room corridor. The outlets, with connection for grounding, should be located so that any bed can be reached conveniently with a cable not longer than 35 feet.

In the lightproof rooms, the lighting requires special attention. Double circuit ceiling fixtures should be provided, giving indirect white and colored illumination. The white light should be controlled by a switch located out of reach of the casual visitor, and of a type more difficult to manipulate so that one cannot thoughtlessly do harm by brightly illuminating the room. In addition, amber, red or green floor illumination should be provided in these rooms. In the fluoroscopic room, the colored illumination should be arranged in such a manner that it can be controlled also from the x-ray foot switch.

All machine rooms should have flush ceiling lights controlled from the outside. In addition, a 110-volt outlet for trouble light should be conveniently located in the control rooms. It is desirable to provide wall mounted fixtures above each control board. Ample electric outlets (110-volt) should be located in the viewing room, for viewing cabinets and the stereoscope, and also in the barium mixing room for the electrical mixer.

Protection Against Stray Radiation

Adequate safeguards are essential to avoid harmful exposure to the roentgen rays by the personnel who are daily in the proximity of the source of the radiation.

This may be accomplished partly by limiting the radiation given off by the x-ray tube to that actually needed for diagnostic or therapeutic purposes. Modern x-ray tubes are enclosed, therefore, in a protective shielding usually of lead or its compounds. A small aperture is provided for the passage of the fractional part of the rays actually used.

With this arrangement it is still necessary to protect against the primary beam passing through the aperture, as well as the secondary or scattered radiation given off by any object the rays may strike. For this purpose, lead lining is today considered the most effective. Materials such as barium plaster may be satisfactory when first installed if the mixing and application are done strictly in accordance with proper specifications; however, the possibility of later cracking with resulting x-ray leakage is always present. The exact thickness of the lead lining depends upon a number of conditions, most important of which is the voltage at which the x-ray tube is operated. The relation between voltage and minimum thickness of lead, as recommended by the International X-Ray and Radium Protection Commission, is indicated below:

Type of Work	X-rays Generated by Peak Voltages	Min. Equiv. Thickness of Each
Fluoroscopy	75 kv.	1.0 mm.
Radiography	100 kv.	1.5 mm.
Skin therapy	100 kv.	1.5 mm.
Medium therapy	150 kv.	2.5 mm.
	175 kv.	3.0 mm.
Deep therapy	200 kv.	4.0 mm.
Deep therapy	225 kv.	5.0 mm.
Deep therapy	250 kv.	6.0 mm.
Deep therapy	300 kv.	9.0 mm.
Deep therapy	400 kv.	15.0 mm.

In actual practice the determination of the protective lead equivalent required in walls, floors and ceilings is somewhat more complicated if economical and yet effective construction is desired. The increased use of x-ray tubes with complete protective shielding reduces the protection needed in building construction. On the other hand, the tendency toward higher radiation output results in a greater quantity of stray radiation. Table II is intended to show the protection required for the various types of x-ray rooms, with due consideration of the size of equipment and assuming the use of protective tubes.

When x-rays are used therapeutically, it is essential that the operator's position be located completely outside the x-ray room behind properly lead-lined walls and door. In diagnostic work, where rayproof tubes are used, a lead-lined partition 7 feet high will suffice if of ample width (see arrangement in accompanying floor plan).

To offer complete protection it is essential that the lead be unpierced and that the joints overlap (about 1½ inches). When lead glass windows are provided these should have a lead equivalent equal to that of the wall or door in which they are mounted.

The glass should preferably be a single thickness; otherwise poor vision may result from an accumulation of dust and moisture between the laminated sheets. The distance from floor to the center of the window should be about 60 inches, and the size of the glass 12 by 16 inches or more. Outside walls or windows need no protection unless the distance to neighboring buildings is less than 20 feet for radiography or 30 for therapy.

To avoid any future uncertainty about the protection offered by the lead glass windows, it is advisable to have the certified lead equivalent etched on the glass. Similarly, a color scheme can be used to indicate the extent and thickness of the lead sheeting hidden in the wall.

It is further recommended that the protection work be done by contractors who have had actual experience in this work.

So far we have considered the layout for the present type of equipment only. Special construction of the rooms to accommodate the particular type of equipment would be desirable. A study of equipment construction trends should be made prior to any decision as to the layout of the radiologic department. The recent development of the self-protected x-ray tube has permitted the reduction of the lead content of the walls. Today, the shockproof line of equipment appears, and apparently will remain. The apparatus of tomorrow cannot be predicted; certain of it, as the vertical fluoroscope, may be wall recessed and it seems probable that the x-ray tubes will be suspended from ceiling mounted tracks as a means of tube, apparatus and floor space economy.

The information and data here presented are based upon our experience in the planning of radiologic departments for municipal and private hospitals and are offered as a guide only. We are appreciative of the difficulties of establishing any set of rules and figures which are applicable to all types and sizes of hospitals; the radiologic needs of institutions differ and every radiologic department must be planned with consideration of its special present and future requirements.

"Radium Hen" Helpful in Guarding Radium Supply

The United States holds more than half of the world's supply of radium, or 256 grams, it is said. The world's supply is valued at $18,000,000 or thereabouts.

How is this nation's supply distributed? Hospitals have 100 grams; 287 of them possess varying amounts of the most valuable of all minerals. Forty grams are held by 414 physicians; six grams by nine laboratories, and the remaining 110 grams by institutions and physicians.

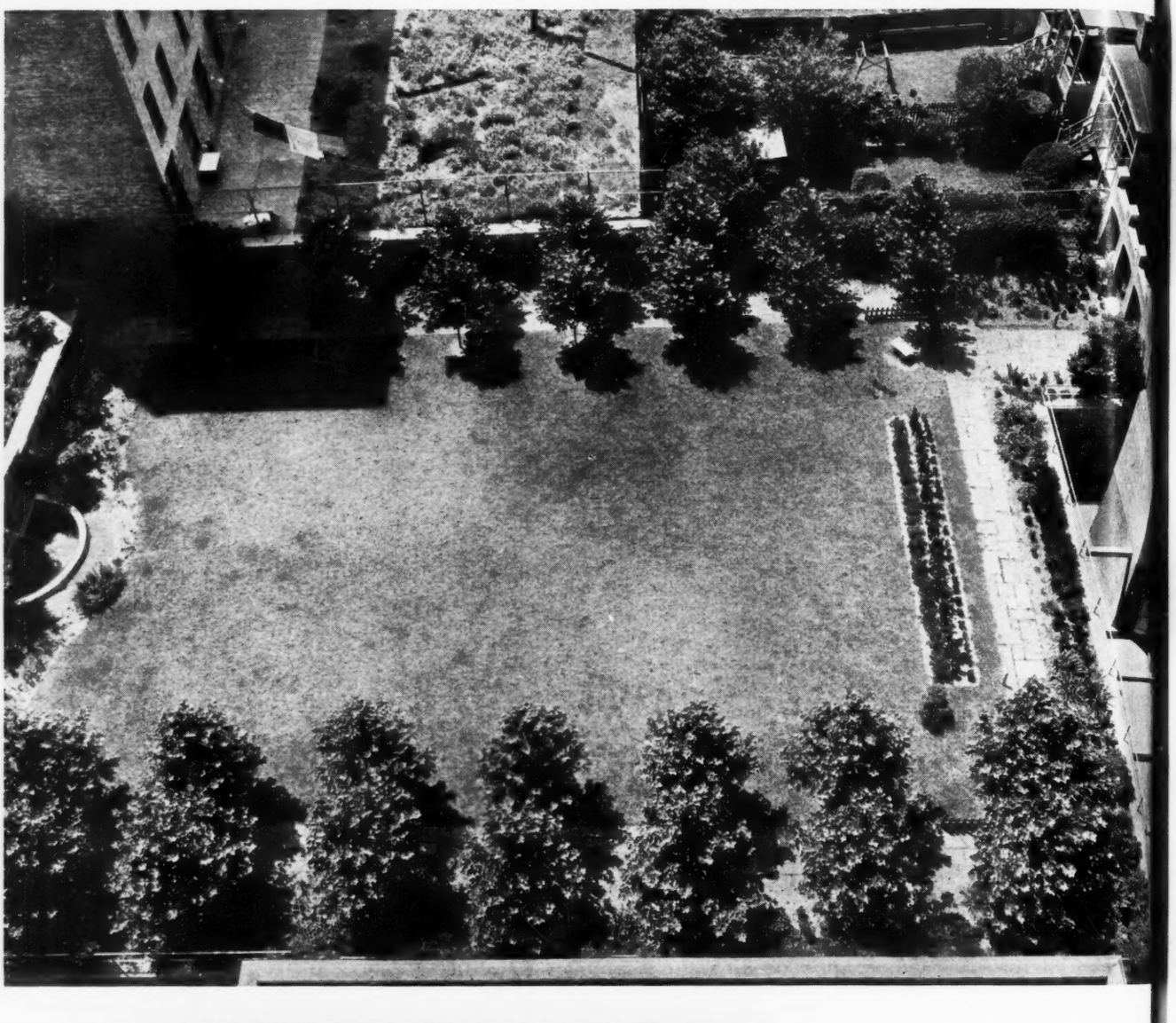
All sales of radium in this country are made through the U. S. Bureau of Standards, which certifies the weight and seals the element in containers. The pitchblende ore in the Belgian Congo assays so high that fields in Colorado and Canada have been almost driven out of competition in the world markets.

Radium bombs, packs or teleradium are possessed by seven institutions and individuals in this country. Bellevue Hospital, New York, has the largest; it contains five grams. Memorial Hospital, New York, has a four-gram pack. Michael Reese Hospital, Chicago, has two bombs, and the Oncologic Hospital, Philadelphia, and New York State Hospital, Buffalo, each possesses one. The other is owned by a radiologist in New York City.

London hospitals recently report the use of the "radium hen" as an aid in finding lost radium needles. Invented by the National Physical Laboratory in England, the instrument gets its name from the clucking sound it makes when placed near radium. The nearer it approaches the valuable element, the more rapidly and excitedly it clucks.

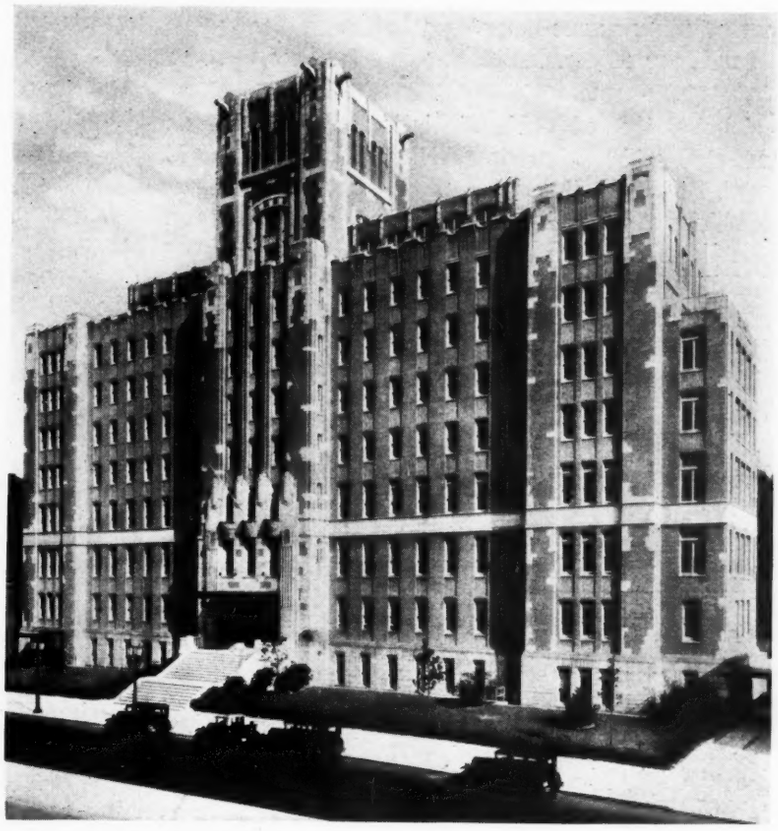
The instrument, according to the London correspondent of the *Journal of the American Medical Association*, looks somewhat like a garden syringe, but behind its brass-cased head is a neon lamp and a trail of flexible cord leading to a box of high tension electric batteries. The neon glows when the electric pressure is sufficient to cause a discharge through it. The pressure is so adjusted that the lamp just misses lighting. The radium radiation pulls the trigger, as it were.

Because the lamp is sensitive to daylight, it has to be covered and therefore cannot be used as an indicator. An electric current flows through the lamp when it is lighted and the current is converted into sound either by use of head phones or a loud-speaker, which clucks in correspondence to the flashing of the hidden lamp. Costly losses have been prevented by its use, it is reported.



A garden spot in the Bronx, which is unusual these days. The gift of one of the directors of The Bronx Hospital, the green lawn, trees and shrubs are enjoyed by patients and employees, as well as visitors who find it a restful place to wait when occasion demands. Looking down the garden path who would know that it leads to the wing of a modern hospital?

The Bronx Formula—Volume Up, Costs Down



By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

A SUBSTANTIAL buckram-bound ledger in an office of The Bronx Hospital, Bronx, New York, tells the story. There can be no denying its authenticity, for it is all there in figures, and figures do not lie. Alongside it, too, are other records furnishing undebatable proof of accomplishments during three of the most difficult years in business history during which a new hospital, engulfed in an unforeseen economic maelstrom and almost wrecked on several occasions, has been successfully salvaged and re-launched with distinction in smoother waters.

As reliable as they are, figures require study. Furthermore, they lack the warm interest of human achievement. Then it is not everyone's privilege to travel through New York's busy streets over the Harlem River for a personal inspection of what is happening in the Bronx. Some interpretation, therefore, becomes necessary.

That buckram-bound ledger in the office of William B. Seltzer, superintendent, typifies knowledge — accurate knowledge on the operation of each department, month by month, year by year. It is the hospital's business Bible and an index of professional achievement. Little need of investigating further. The facts are there.

It opens at a report of the dietetic department. It is possible at a glance to ascertain the per patient day cost by month for each type of food. A few pages beyond is a similar record of all drugs consumed. Then come several pages devoted to x-ray statistics, the number of patients x-rayed, the films used and the ratio of films per patient.

It is interesting to stop at these pages and contemplate a bit. Why this increase over last month in the ratio of films per patient? It is evident that the figures have been growing larger steadily. This necessitates a conference with the head of that department within the next few hours. The mystery is explained but discussion is fruitful, nevertheless. Substituting a smaller plate for the larger size will be equally effective, it is agreed, yet reduce costs considerably.

Another section of the book reveals additional hospital information. It is not alone the purchase and consumption of commodities with which it is concerned. Now we are getting down to facts indeed — mortality statistics. Every death is listed under the doctor's name, affording a check on each man's record. Figures on maternity work are kept separately. Incidentally, the hospital boasts a particularly fine record in its obstetric division. The figures show 1,600 deliveries last year.

Pay roll analyses are likewise included, arranged by departments. Among other significant

details are the number of employee days in various departments by month and year.

Recording this vast amount of information in the ledger is not the task it may seem. Every department head sends in each month a complete report. A girl trained for such work enters the figures. Soon the story is complete. It is a fascinating task, as she herself will affirm, from which all manner of conclusions and deductions may be drawn at any time.

The value of such statistical data depends largely on the extent to which the information is used. It can be merely another extravagance — a mechanical operation which means more red tape and little else. Or it can form a vital fund of knowledge upon which the superintendent can constantly draw. Mr. Seltzer considers this record control the central key to the business and professional activities of the hospital. Through this he has specific and immediate data always available.

Two factors are responsible for bringing The Bronx Hospital through the doldrums of despair to the point where it is practically meeting operating costs — the application of business methods to its management and upholding the volume of service rendered. Its occupancy rate averages between 75 and 80 per cent.

What has transpired is particularly significant when the history of the institution is traced back a few years. In 1911 a group of physicians practicing in the Bronx felt the need of a building where they might take their patients in emergencies. They organized for this purpose a clinic known as the Bronx Hospital and Dispensary. Nine years later, as the need for hospitalization became greater, some laymen joined the ranks with the medical men and in a home which once housed one of the old wealthy families of the community established a hospital of eighty-six beds and twenty bassinets. At that time the board of directors comprised eighteen laymen and four or five physicians.

A New Building Was Needed

Within two or three years it was agreed that a new building was necessary, there being only one other voluntary hospital in the borough. This decision was reached at a time when prosperity was at its height. The board of directors, all laymen, donated $900,000 and additional pledges were secured. Plans were drawn and building operations started in 1925.

It was not long when the pinch of hard times was felt. Pledges made only a short time before were found to mean little or nothing. Negotiations to effect a merger with the only other voluntary hospital in the Bronx did not materialize. Work was halted pending a satisfactory solution to the problem.

The year 1929 found the building about ninety per cent completed but with no equipment provided for, and all work halted. Again the question of a merger was considered and again the plan fell through. Finally, through the generosity of some of the original directors, loyal to the community in which they had grown up because of the business opportunities it had afforded them, an additional sum was raised. Back salaries were paid and such amounts as were necessary to get the contractors to complete their work. The chances for getting paid were far better with the hospital opened than with it closed, it was pointed out.

So with such equipment as could be moved from the old building, with additional purchases made with the very limited sum available, the hospital finally opened its doors to the public in 1932, offering a building with a potential occupancy of 303 beds and 59 bassinets.

Many Factors Contributed to Success

This inauspicious start coupled with the continued depression demanded careful management and the closest supervision. It required loyalty on the part of employees and a cooperative spirit on the part of the medical staff. It meant constant generosity on the part of the directors, coupled with constructive guidance, leaving at all times the execution of formulated plans in the hands of the superintendent. It called for keen business management by him. What has been accomplished within the short space of three years attests to the value of business principles as applied to hospital operation.

"Keep your volume up and your expenses down" is the answer. Obviously, there can be no other. But how is it to be accomplished? What steps can be taken to fill those empty beds? Physicians and surgeons on the staff are the key men to the situation. They, and they only, possess the power to fill the hospital's vacant beds provided the hospital gives good service to the patients.

The situation at the Bronx was put before them frankly. The hospital could not hope to survive and keep its doors open without their cooperation. Local men, most of them, they were quick to rally to the support of the institution. Its services were needed in the community. Furthermore, they recognized its value to them as individuals in their professional advancement, the opportunities it afforded them for scientific research. Soon, fewer empty beds were noticed in wards as well as in private rooms. Today about 50 per cent of the work is private and semiprivate.

Having had impressed upon them the need for

SHEETS 63x99 THE BRONX HOSPITAL Unit-Dr

ARTICLE DESCRIPTION

MIN. MAX.

1 Superior Linen Co. 4
2 Baker Linen Co. 5
3 6

ORDERED				RECEIVED							ISSUED			BAL.
VEN.	DATE OF ORDER	ORDER NO.	QUANTITY ORDERED	PRICE	DUE TO BEGIN	VEN.	DATE	RECD. NO.	QUAN.	UNIT PRICE	AMOUNT	DATE	QUAN.	AMOUNT	QUAN.
1	7/11/35	9924	20	9¼	Orders			4/5	43 9/12	11.08	483 82	July 1934	1 4/12	16 62	42 9/12
2	7/11/35	9925	20	9¼	9922	1	7/11/35	7209	10		92 40	Aug	3	30 24	39 9/12
3	8/10/35	5765	20	9¼	9922	1	7/11/35	7262	10		92 40	Oct	1 4/12	16 62	35 9/12
					9921	2	7/11/35	7662	20		184 40	Dec	4 9/12	48 09	33 3/12
												Jan 1935	7 4/12	83 10	25 7/12
												Feb	3 11/12	43 40	22
												Mar	7 12/12	79 40	14 12/12
												Apr	2	22 16	12 12/12
												May	4	44 32	8 12/12
												June	4 9/12	46 16	4 3/12
												July	3 9/12	35 08	21 4/12
												Aug	6 9/12	69 82	35

Sam Smith
Cary

886—Remington Rand Inc.—13 200-10870-AB

Perpetual inventories are kept in visible indexes.

using the hospital's facilities, the doctors are kept mindful of their obligation to the institution as members of its staff. With other information which comes regularly to the superintendent's office and which finds its way ultimately into the central control as a permanent record, is a report of admissions by doctors for each month. This lists the number of private patients for the month, also cumulative for the year, likewise, the number of semiprivate, ward and free patients and the number of maternity patients for the month and year.

Only two conclusions can be drawn from the fact that a doctor is treating fewer patients in the hospital. Either his practice is falling off or he is caring for them elsewhere. Despite the large and steadily increasing population of the Bronx and the fact that it covers a wide area, it is a home town after all. This makes it comparatively simple to check on each individual.

If it is found that a doctor is not referring as many cases as previously he is asked frankly what the difficulty seems to be. This appeal is made on the assumption that perhaps his patients have had complaints about the service they received which have not come to the superintendent's ears. If so, he is urged to pass them along and at the same time is assured that others of his patients will be carefully safeguarded against similar inattentions. Such solicitation of specific objections has helped clear the atmosphere. It has also contributed to maintain a high rate of occupancy.

It is expected that there will be complaints. There always are. The problem is to uncover them and by knowing the weaknesses to work constantly toward strengthening the service at these points of weakness. The doctors are encouraged to report inadequacies at all times directly to the superintendent who investigates these complaints and if the doctor is not justified he is told so and if he is justified, the causes of complaints are removed.

One other demand is made of staff members. They must attend the monthly staff meetings of their particular departments. This is essential for promotion and reappointments.

Reference to the nursing situation suggests an interesting solution to a major problem. The hospital has no training school and employs only graduate nurses. Its inability to pay attractive wages has made necessary frequent changes which is, of course, always unsatisfactory. Finally, arrangements were effected with the training schools of one or two hospitals in smaller communities outside of New York. For the sake of the opportunities afforded by big city life, many girls graduating were glad to sacrifice a bit on their salary. Thus, it has been possible to get a better type nurse and to keep her satisfied longer than could be expected of girls trained and residing in Manhattan.

It has been explained how volume is maintained in The Bronx Hospital. Next comes the question of cutting down expenses.

Business routine is followed closely in requisitioning supplies and checking all bills. Orders are made out only by the dietitian, the pharmacist and the purchasing agent. These are prepared in triplicate and countersigned by the superintendent

F1 3M-P.P.Co.

THE BRONX HOSPITAL
EMPLOYEE RECORD

Phone _____ Dept. Dietary

Name Smith, Joan No. 53 Address 1287 Fulton Avenue, Bronx, NY

Position Kitchen Man Salary ~~$50.00~~ 45.00 Commenced June 8, 1933

Replacing and Whom Thomas Murrisey Position Same Salary $50.00

Nearest Relative Wife-Mary Address Same Meals 3

Social Condition Married Maint. No

Where Employed in Similar Position Presbyterian Hospital How Long Employed 2½ yrs.

Reference Dietitian

Dept. Head A Goldberg Auditor A Crowley Supt. M Belzer

VACATION			LEAVE OF ABSENCE										LEFT EMPLOYMENT
From	To	Days	Date	With Pay	W'out Pay	Date	With Pay	W'out Pay	Date	With Pay	W'out Pay	Date	With Pay	W'out Pay	
7/11/34	7/18/34	7	1/15/34		✓		>								Date Resigned
8/25/35	9/1/35	8	9/1/34	1											Reason
															Date Discharged
															Cause
															Approved by SUPT.

Medical Examination 193

I have examined the above applicant and found _____

_____ M. D.

with the exception of orders for such commodities as fruits, vegetables, meats, poultry. One copy goes to the vendor, the other to the accounting department, while the third is kept by the person making out the requisition.

All goods are received in one place between certain hours. It is a rule that no one can accept any merchandise other than the receiving department. Receipts are made out in duplicate, the original being sent to the accounting department and the other copy kept by the receiving department.

Careful Checking Eliminates Errors

Bills coming to the main office are reviewed by the superintendent and then sent to the accounting department. Each bill is checked against the order for price and quantity, and is also checked against the receiving order which if it happens to cover drugs or poultry, vegetables or meats, has already been countersigned by the department head for quality. The bookkeeper prepares a voucher of all the bills for the month, attaching the copy of the order and receiving record to the bill so the voucher in itself tells a complete story of the ordering and receiving of the merchandise, and it is not necessary to refer to any other records if one wants to review the voucher at some future time. The accountant then checks for extensions and classifications, and the complete information is passed along to the superintendent for his countersignature.

With such careful checking, there is little possibility for errors. In consequence, those supplying the hospital are disinclined to take any chances. They risk no short measures, overcharges or other inaccuracies.

Perpetual inventories of all commodities are kept in visible indexes. These show the date of order, the order number, the quantity ordered and the price. Similar information is listed covering goods received. A third column gives the date, the quantity and the amount of the issuances. A fourth column shows the quantity comprising the balance.

Extreme care is exercised in checking all requisitions. The linen room, for example, puts in a requisition for a certain number of new sheets accompanied by those being taken out of circulation. The purchasing agent checks the requisition and the sheets turned in. He may feel that a certain number still are fit for use. He returns these to the linen room for repair and reduces the amount requisitioned.

It is not all cold busines régime in The Bronx Hospital, however. Close contacts are maintained with patients to make sure they receive good service. The same system of close checking is revealed.

The hospital is fortunate in having in the post of liaison officer a soft-spoken English woman whose sole duty it is to visit with the patients to see that they are as happy and comfortable as possible under the circumstances and to make note of any complaints they may have. Her training as a nurse enables her to approach medical problems intelligently. Yet she never wears a nurse's uniform. Simple street clothes, it is found, encourage confidences. Each day she makes her complete rounds, giving special attention to patients in a critical condition and also to their families. She even visits families outside the hospital and lends assistance when death occurs. She has been particularly successful in dealing with highly emotional types, and has helped in securing permission for postmortem examinations.

It is not surprising when visiting the maternity division to discover a nurse addressing a group of mothers on the care of the infant. This is, in fact, a regular procedure which takes place on the ninth or tenth day after the delivery, provided, of course, that the patient has convalesced sufficiently so that she can attend. All patients are invited, whether they be in private rooms or wards.

As the mother leaves the hospital she is given a souvenir in the form of a baby record book, decorated in color and providing ample space for jotting down the dates and details of the baby's first experiences. Mr. Seltzer was fortunate in being able to purchase many thousands of these at an extremely low price.

A few days after a patient returns home, he receives a letter from the president of the hospital.

"The Board of Directors begs to express the hope that you have fully recovered from your recent illness for which you were treated at The Bronx Hospital.

"We know that your stay at the hospital has rendered you particularly fit to offer constructive criticism, and as we are intensely interested in perfecting our service as far as it lies in our power to do so, we would indeed appreciate your reply as to how the service given has appealed to you.

"With our best wishes for your good health, we are . . ."

Constant checking tells the story. Yet the story is only half told. That substantial buckram-bound ledger in Mr. Seltzer's office is only a means to an end, which is, greater facilities for treatment — more clinics — better opportunities for research and laboratory experiments. Its importance as typifying business methods in their application to hospital administration cannot be denied, nevertheless.

Protecting Your Employees—

By an Inexpensive and Simple Method

By LEE K. FRANKEL, JR.
New York City

HOSPITAL executives have been compelled to face a serious problem the past few years in connection with the low pay scales which curtailment of incomes and endowments has made necessary in order that relief, medication and hospitalization might continue. Housekeeping, engineering, maintenance, administration and general employee wages have been trimmed to the bone. Dissatisfaction among such workers is rapidly spreading, as is indicated by the attempts at organization now being initiated among some New York hospitals by a newly formed workers' association. Directors have been unwilling to vote a budget for more than the actual running expenses of the hospital. Yet the routine of hospital work must continue unimpaired if the institution is to function efficiently.

Perhaps one of the causes of discontent among hospital workers lies in the fact that low wages permit of no feeling of security in the event of premature death. Sickness, accident and disability, when they afflict the hospital employee, will be relieved in most cases by the institution itself, but his sudden death, whether sustained on the job or off, hits the employee's family with a jolt which the average employing hospital is in no position to alleviate.

Helping the Perplexed Superintendent

Group life insurance programs, as administered and installed by any of the six larger companies which offer them today, provide the perplexed hospital superintendent with a simple, comprehensive and inexpensive way out of a distressing situation. They make it possible for all employees to secure substantial death benefits, at an annual cost to the hospital which ranges between ½ per cent and 1 per cent of pay roll, on the average. These plans permit the hospital to discharge its inherent obligation to a faithful employee's family in the event of his death; they impose no unreasonable strain on the budget or on the temper of the board of trustees, and they impart a feeling of security to the insured employee, causing him to feel that his hospital has an interest in him which extends beyond his actual conditions of employment into the welfare and future of those he holds dear.

Group life insurance plans are divided into two broad categories. Under the first of these, the employing hospital insures all its employees, or all of a certain class of employees, according to a predetermined schedule of benefits, and pays the entire premium therefor. Under the second, eligible employees and hospital share in the premium cost. This is known as the contributory or cooperative plan and is the most popular and widely adopted form of group coverage.

Spreading the Risks

Under the contributory set-up, state insurance laws require that at least 75 per cent of the eligible employees must subscribe to the plan before it can become effective. This regulation is sound from several points of view. It assures the hospital in advance that at least three-quarters of the employees to whom protection is offered appreciate the gesture sufficiently to chip in their small share; and it also protects the insurance company against what is known as adverse selection, that is, receiving applications for insurance from the older and physically impaired risks. By spreading the risk over at least 75 per cent of the employees who are to be insured, the underwriting company balances the older risks with the younger and healthier applicants.

Group life insurance is written without medical examination on groups of at least fifty lives. It is technically known as "one-year renewable term" insurance, and the premiums are calculated for the group by taking the premiums at each age to be insured, totaling them and dividing by the total amount of insurance to be issued. This yields a basic rate, which is usually guaranteed for a certain period of years. It is not necessary to have this calculation performed in advance, as the insurance companies are able to estimate the rate accurately, due to the hundreds of thousands of lives they have insured under similar plans in general industry.

The most satisfactory way to offer group protection to a staff is to base the amount of insurance per employee on his or her salary. The accompanying imaginary schedule will provide an idea of benefits, cost to employee and cost to hospital per employee.

Under most state regulations, employees may not contribute more than 70 cents per month per $1,000 of insurance. They may contribute less, de-

TABLE I—AN IMAGINARY SCHEDULE SHOWING BENEFITS AND COSTS OF GROUP INSURANCE

Salary Class	*Amount Insurance per Employee*	*Estimated Basic Monthly Premium*	*Employee's Fixed Share*	*Hosp. Est. Share per Employee*	*Est. No. Lives in Class*
Under $80 mo.....	$ 500	$0.42	$0.35	$0.07	100
From $80-$120 mo.....	$1,000	0.84	0.70	0.14	50
From $120-$200 mo.....	$1,500	1.26	1.05	0.21	25
Over $200 monthly.....	$2,000	1.68	1.40	0.28	10

pending on the generosity of the hospital. Table I is based on a legal maximum contribution by the employee.

From this basic schedule, we can estimate just how much the plan, if adopted by the required majority of the employees, will cost the employing hospital.

This imaginary hospital has an annual pay roll of about $158,000. To cover this entire pay roll with a death benefit for each employee in the amount of his or her approximate annual earnings, the hospital will be faced with the following budgetary increase:

Noncontributory Plan (hospital pays all): $1,590 yearly, —1 per cent of pay roll.

Contributory Plan (shared by employees and hospital): $265 yearly, —1/5 of 1 per cent of pay roll.

Premium Is Low

On analyzing this estimated cost, it will be found that the contributory plan of group protection requires a contribution from the hospital of approximately one-fifth of a penny for each dollar of salaries and wages. This cannot be considered excessive, even with depleted budgets and increasing costs of administration, especially when it is remembered that a sudden epidemic or catastrophe might cause the payment of many thousands of dollars in death claims.

The life insurance companies which write group insurance have developed a simple and successful method of presenting the benefits of the plan to hospital staffs. The director simply permits the company to prepare a leaflet describing the plan, listing the insurance which can be purchased, and the contributions per employee and advising the personnel that the hospital is ready and willing to contribute its share, provided the employees accept the plan. Meetings are then held in each department by a company representative, who describes the advantages of group insurance, answers all questions and assists employees to complete their individual subscription card. These cards authorize the hospital to deduct each employee's share of premium from his pay, once a month.

Rate Calculated From Age Data

Assuming that the necessary percentage of eligible employees apply for the protection, the actual rate is calculated from the age data supplied by the individual cards, and the premium statement is presented to the hospital, which usually advances the first month's premium and thus makes the insurance binding and in force. The hospital reimburses itself at the end of the month by deductions from pay roll.

The actual bookkeeping required to keep a group plan operating efficiently is simple. Deductions are made once a month; new entrants into the plan, and cancellations, are reported to the company at the same time on specially prepared forms; death claims are paid at once, on the certificate of the attending physician. For a hospital employing 200 people the paper work should not

TABLE II—COST TO EMPLOYING HOSPITAL

Salary Class	*Number of Lives*	*Insurance per Life*	*Total Insurance in Class*	*Total Estimated Monthly Premium*	*Total Monthly Cont. by Employees*	*Estimated Monthly Cont. by Hosp.*
1	100	$ 500	$50,000	$42.00	$35.00	$ 7.00
2	50	1,000	50,000	42.00	35.00	7.00
3	25	1,500	37,500	31.50	26.25	5.25
4	10	2,000	20,000	16.80	14.00	2.80
	185		$157,500	$132.30	$110.25	$22.05

Total Estimated Annual Premium	$1,587.60
Total Estimated Annual Contribution by Employees	1,323.00
Total Estimated Annual Contribution by Hospital	264.60

require more than one hour a month of work for the employee in charge of pay roll.

In most groups, all employees at work when the plan is offered are considered eligible for benefits. New employees are usually required to wait three or six months before becoming eligible. This prevents undue turnover and record keeping and re-

duces the hospital's cost, as it eliminates any contributions by the hospital for "floaters."

Employees have certain valuable privileges under a group life contract. Upon termination of employment, the employee may convert his individual certificate of insurance to any form of policy contract written by the company, with the exception of term insurance. His new policy will be issued to him without medical examination, and at the rate of his attained age, provided he applies for it within thirty days after his employment ends. This is often a valuable provision in the case of older employees, who are uninsurable, as it provides a perfect hedge against their physical condition in the future. Inasmuch as group insurance is essentially term insurance, there can be no cash surrender value for either employee or hospital when employment ceases.

Four of the leading group insurance companies issue contracts on the participating or dividend paying basis. A dividend is based on the mortality experience of the group, and is payable each year, if earned. This dividend is almost always retained by the hospital to reduce its outlay, as it would be impractical to divide it among several hundred people. In some instances, when the dividend is substantial, it can be used to purchase additional free insurance for certain classes of employees.

TABLE III—$1,000 INSURANCE, MONTHLY PREMIUM

Age	*Group Rate*	*Industrial Rate*	*Ordinary Life Rate*
20	$0.70	$1.72	$1.52
30	0.70	2.30	1.95
40	0.70	3.14	2.69
50	0.70	4.70	4.00
60	0.70	7.94	6.29
70	0.70	Not Issued	Not Issued

Group protection finds ready acceptance by employees because of its extremely low cost as compared with any other form of life insurance purchased individually in the open market. Table III gives a condensed comparison of the cost of protection under the ordinary or straight life basis; the industrial or weekly premium basis and the group basis. The differences in favor of group rates are obvious.

It should be remembered that certain hospital workers are classified individually by insurance companies as rated or substandard risks. X-ray technicians, anesthetists, electricians, nurses in contagious disease wards, would all be charged extra premiums on individual policies to cover the extra occupational hazard. This extra loading is done away with in group rates to the employee. In addition, group insurance carries a total and permanent disability provision which would carry an extra charge if it were to be included in individual policies.

Group insurance is really insurance sold at manufacturing cost, at the lowest premium consistent with good underwriting practice. The insurance company has no collection expense, as the hospital acts as a collection agency for it, making deductions once monthly and sending one check to the company. Commissions paid agents are small as compared with other forms of protection; medical examination fees and retail credit information fees are eliminated. The company is wholesaling protection, and covering its risk by taking in at least fifty people under one master policy, being protected against adverse selection by the 75 per cent participation requirement. It is not a "bargain," but the scientific application of actuarial principles to mass distribution of risk.

Properly installed and maintained, a group insurance program can be woven into the daily life of a hospital so as to become an integral feature of its personnel policy. At an insignificant outlay, trustees and officers will have the satisfaction of knowing that almost a year's salary or wages will be paid to an employee's dependents in case of sudden death while employed. The increase in good will, improvement in morale and growth of esprit de corps, while intangible, can be gauged by the decrease in suspicion, and the growth of cooperation which will pervade any group of workers once they realize that their employer's interest in them goes beyond the job, into the home.

Meeting the Problem of Cracked and Scaled Paint

Old paint that is cracked and scaled generally over the entire surface presents a difficult problem in repainting. If the scaling resulted from the use of cheap, poor paint or from the application of paint over glue size that was too strong, it should be removed completely to permit the new paint to anchor firmly, says *Buildings and Building Management* in an article giving practical pointers on painting and decorating.

The complete removal of such paint may be difficult to achieve. Sometimes the old paint can be sanded and scraped off at a reasonable cost, but in some cases only liquid paint remover will do the job. If the expense of such removal is too great, the next best method, it is stated, is to remove all paint that will come off fairly easily, sandpaper the edges of what remains, touch up the bare spots from which paint has been removed with a coat of paint and then repaint the entire surface.

When paint has cracked and is peeling off only on areas that have been water soaked, there is no need to remove the paint from the entire surface. Removing it around the water soaked area by scraping and sanding and touching up such spots with paint is sufficient preparation as a rule.

What Others Are Doing

Author's Garden Benefits Hospitals

In England it is customary for owners of beautiful estates to open their grounds to the public during the time when the gardens are gayest, the small fee collected going to a general fund for the hospitals.

This summer Beverley Nichols whose books "Down the Garden Path" and "The Thatched Cottage" have been read with delight by nature lovers on both sides of the Atlantic opened his own garden path and thatched cottage to all comers at a stated season. Mr. Nichols not only allowed visitors, in this hospitals' benefit, but personally conducted them around his domain.

From London and various parts of England and even from America, Nichols enthusiasts have made pilgrimages to Glatton in Huntingdonshire, where the now famous cottage stands.

A successful benefit for the King Edward Fund in aid of British voluntary hospitals is the annual series of mock trials. In these "some celebrated person or persons must answer a charge productive of an hour's witty exchange," to use Frank Swinnerton's language in describing the idea.

This year's series of trials began with an arraignment of certain English film stars and producers on the ground that they had been falsifying history. The prosecution was in the hands of Philip Guedalla, while defendants included not only Cicely Courtneidge but Beverley Baxter, late editor of the Daily Express and now a dominant personality in the Gaumont-British Corporation. The judge was Theo. Matthew, one of the wittiest men at the English bar.

The Power of Suggestion

A novel use of the power of suggestion is employed by Grace Hospital, New Haven, Conn. In the hospital's current annual report is inserted a leaflet entitled "Needs of Grace Hospital." In the introduction to the leaflet, Sidney G. Davidson, superintendent, says "At Grace Hospital every effort is being made to improve the service, the equipment and the physical condition of the buildings, in order that patients may receive the best possible care."

The succeeding pages are devoted to pictures and descriptions of various types of equipment needed. Included are a new type of bed for serious fracture cases of which the hospital needs five, new dressing sterilizers of which two are needed, new instrument sterilizers (three needed), new utensil sterilizers (four desired), a new water sterilizer, bedpan sterilizer (four needed), a new operating table, a new deep x-ray treatment machine, new bedside tables, and comfortable beds (any number can be used).

There is also a picture of a well furnished private room, which has been refurnished for $200. The prices of each item of equipment are given. They range from $18 for a new bed to $6,000 for the new x-ray machine.

Hospital Finance in a Fishing Community

Everything economic in Newfoundland, including the Notre Dame Bay Memorial Hospital at Twillingate, depends upon the price of fish. Last year both the catch and the price were poor.

The hospital arrived at its tenth birthday and looked out upon a bleak and depression-ridden world. During the first ten years it had suckled from the springs of the Newfoundland government and donations from the United States. With great alarm it saw these sources of income dwindle to half their accustomed amount.

Dr. J. M. Olds, medical superintendent, and the board of directors were able to reduce expenditures to $45,000 through various economies and reduction in salaries. The government appropriated $25,000 to the hospital and some gifts came in. But there was still an apparent deficit of $18,000, less a possible $3,000 as probable income from patients.

To meet the expected deficit, a prepayment policy was adopted in July, 1934. The hospital agreed to sell a family a "contract" for $10, which assured all members of the family all necessary hospital care for one year without other expense except half-price for operations (the maximum charge for a major operation is $25), x-rays and laboratory work.

Few people among the 36,000 served by the hospital were able to afford $10 for anything, it soon became apparent. What should be done next?

In September of last year another contract was offered to one community. This contract agreed to give all necessary hospital treatment to all members of the community upon the payment of 44 cents a head for every member of the community.

The so-called "blanket contract" immediately became much more popular than the $10 scheme. Apparently it is within the reach of the community's wage earners. In early August, 1935, however, Doctor Olds reports that only five-eights of the population of the Bay is covered by either contract. There has been a distinct mutual benefit, however.

During the year 1934-35 residents of the Bay, by means of these contracts, paid into the hospital $17,000 as compared to $4,100 the previous year when bills were supposed to be paid in full. The hospital has been able to care for more patients (525 as compared with 476 the year before) and has approximately made both ends meet.

"Ye Doctors' Minstrels" Aid Hospital

Members of the Academy of Medicine, McKeesport, Pa., wanted in some way to assist financially the McKeesport Hospital, where as in other institutions patients' receipts had shrunk considerably. They decided on a minstrel show, all the participants being members of the medical profession.

For two months the doctors rehearsed diligently, and then put on the show to a packed house. The proceeds of $2,000 were turned over to the hospital and will be used for repairs. The physicians had so much fun doing it that they may decide to put on a minstrel show each year.

An elaborate printed program filled with local advertisements helped to swell the proceeds.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

Wider Service to Doctors— A Key to Better Occupancy

By NATHAN S. DAVIS III, M.D.
Assistant Professor of Medicine, Northwestern University School of Medicine, Chicago

THREE years ago, a perfectly apparent need in the field of public health was described as follows[1]: "There is urgent need in many communities for sound regional planning by competent medical and community leaders to secure, distribute and coordinate local facilities and trained personnel through hospital centers, home nursing and medical services, public health activities and other features now recognized as essential. Hospital centers provide the professional and community interest and a type of organization well suited to the development of community health programs in many places." The need is even greater today.

Dr. R. C. Buerki, president-elect of the American Hospital Association, concludes an article in The MODERN HOSPITAL of February, 1935, with words that are a challenge to every medical and hospital man in this country, "We are, I believe, justified in saying that we have a large waste of capital resources in our attack upon disease; that we have, in marked instances, a great deal of duplication of capital goods, and we have a disproportionate amount of capital massed behind the treatment of fractional aspects of disease.

"Because of this we are also wasting the man power of the personnel of medical science at considerable cost to the profession and to the sick.

". . . We know that generally speaking there is one solution of this situation. We must deploy our forces and facilities over a wider area. We must spread our resources horizontally so that the base of our hospital structure can be made more secure through broader service to the community."

Are the suggestions in these statements being carried out? To what extent is the $2,000,000,000 invested in general hospitals for the treatment of acute illnesses being used for the benefit of all those who are sick? These are questions to which the practicing physician everywhere would like to have answers.

[1]Final Report of Commission on Medical Education, New York, 1932, p. 62.

Studies in morbidity are notably inaccurate but indicate that the practice of medicine is distributed somewhat as follows:

Office	55%
Home	35%
Hospital	10%
Surgical conditions	50% plus
Obstetrics	15%
Medical, etc.	35% minus

The material facilities of hospitals have until now been used largely by surgeons, surgical specialists and obstetricians. It is true that in treatment of his individual patients, every physician can and does get service from the general hospital. However, internists, pediatricians, neuropsychiatrists, dermatologists and family doctors, who render medical service to more individuals than do all others put together, use hospitals, as they are organized at present, to a limited extent only. The general hospital is then in practice an institution for surgical and obstetric treatment although in reality it is prepared to render diagnostic and therapeutic services for all acute illnesses. Even when the hospital's beds, its operating rooms and obstetric departments are being used to capacity, the clinical, pathologic and x-ray laboratories, the physical therapy department and the pharmacy are rarely so used; because to offer a well rounded service, their maximum potential capacity, except in the larger hospitals, must be considerably greater than that of the hospital's bed capacity.

Providing for Ambulants

Unfortunately for a rational consideration of hospital service, a hospital's capacity is generally measured by its bed capacity, not by its bed capacity plus its capacity to serve ambulatory patients. Some administrators are beginning to appreciate the need of service for ambulatory patients and the fact that a hospital should and may provide many services for such patients. Some hospitals have provided examining rooms for the use of members of the staff and staff members are mak-

ing more and more use of such facilities. A limited number are furnishing offices in which attending physicians may care for their private practices. More are donating offices in which the physician may care for part-pay and charity patients. However, these facilities are, as a rule, available to only a small proportion of the physicians who need them that they may render more efficient service to their ambulatory patients.

As a result, qualified specialists, even those in charge of hospital departments, have established and equipped offices for the practice of clinical pathology, roentgenology and radiology, and physical therapy in locations convenient to the offices of many physicians and especially to those on the staff of the hospital. It is also unusual for such establishments to operate at capacity, and duplication of expensive equipment, space and personnel increases or maintains at a high level the unit cost of such services.

With all hospitals, except governmental and other charity hospitals, only about 55 per cent are occupied as far as bed capacity is concerned; they are much less occupied as far as their capacity to serve ambulatory and bed patients is concerned. The proportion of the hospital's material facilities actually required for service to private or ward beds is relatively small. The proportion available exclusively for bed patients is smaller.

Making Maximum Use of the Plant

Now, as a matter of fact, if we are to take a rational view we must consider a hospital as we consider a hotel or a manufacturing plant — a hospital is a plant in which we, among other things, repair health. Therefore, what we desire to know about is plant capacity under any form of plant organization. Is it sound business to equip x-ray pathologic and other departments which, if adequate to provide for all possible needs in a general hospital plant, usually have a capacity much greater than the capacity of the balance of the hospital (the bed capacity of the hospital) and not to make every effort to utilize every portion of the plant to its maximum capacity at all times?

"A hospital recently constructed in a midwestern city of 300,000 inhabitants shows the following areas, expressed in terms of square feet, devoted to different features of the hospital; private bedrooms, 38,200; ward rooms, 6,800; stairs, elevators, corridors, offices, etc., 50,000; diagnostic and treatment rooms, 19,000; porches, kitchens, pantries, interns' quarters, storage, etc., 37,000; power plant, 40,000; nurses' home, 45,000."[1]

[1]Rorem, C. Rufus, The Public's Investment in Hospitals, University of Chicago Press, Chicago, 1930.

In such a hospital it is reasonable to assume that not more than 50 per cent of the total material facilities need be used exclusively for service to private or ward patients. When the bed capacity of the hospital is only 50 per cent occupied, it is entirely reasonable to conclude that the plant is operating to only 25 per cent of its total capacity and its laboratory departments, if complete, to much less than this. Under these circumstances personnel is reduced, to be sure, but to a large extent the plant as a whole is maintained in comparative idleness. That means outright waste of opportunity and facilities. Of course we cannot reach this conclusion if we subscribe to the time entrenched error that hospitals are for bed patients only and that there is any close relation between bed accommodations and the plant's total capacity to preserve and repair health.

Why Costs Seem High

Another vital question suggests itself. Do general hospitals have beds available for all classes of patients who are acutely ill? Considerably less than half of the beds in voluntary and proprietary general hospitals are in larger or smaller wards and so-called semiprivate rooms (really the smallest wards). The remainder are in private rooms, many of them with private bath, corresponding in every way to single rooms in first-class hotels. For the indigent not cared for in government hospitals, there are probably enough beds in wards. Considering the number who can really afford them, there are probably too many beds in private rooms. But there is no adequate provision for the great bulk of the population that is accustomed to privacy when well but can hardly afford public or semiprivate ward beds when ill. As a result such people often spend more than they can afford that they may have privacy when ill. This situation plus the laboratory, operating room and private nursing charges has been the principal cause of all the talk about high costs of hospital care.

The personal interests of all medical men, especially of those who do no surgery or obstetrics, are involved in this situation. Capital invested and medical costs per unit are too high because the hospital plant is not so organized that its capacity, including its capacity for service to the ambulatory patient, is effectively used. There is duplication of material facilities, and in the isolated matter of bed facilities, there does not seem to be sufficient provision for the vast majority of those who may be ill — those with incomes under $4,000 or $5,000. These things all result in increase of expense and less efficient care for the patient, and money out-of-pocket for the physician since his bill is likely to be paid last. Although it

is not the physician's direct and immediate problem, it would appear that these things mean loss of revenue for the hospital, too.

Moreover, what some believe to be a serious question of public policy and public intent arises. Did those who furnished funds for hospitals believe they were constructing plants to be used mainly for surgical and obstetric cases or plants to be used as effectively as possible for the care of all sick? In recent campaigns for funds for general hospitals they have been featured as medical centers rather than as surgical and obstetric institutions.

However that may be, taking the whole situation as we find it, what can now be done to make hospitals real centers for medical service; centers in which all the acutely ill, except the 35 per cent cared for in their homes, may be served at moderate cost? In particular, four things may be done.

1. Small, simple private rooms and cubicles for the acutely ill of moderate means may be provided at costs they can afford to pay. When in a hospital for diagnosis or when convalescing, such patients may, to economize and avoid solitude, take beds in small semiprivate wards if they can be assured that their roommates will not be seriously ill, will not have just had a major or minor surgical operation, and will not require distasteful nursing services.

The Advantage of Cubicles

Privacy for those of moderate income can in many cases be obtained by building cubicles in some of the larger wards. This would not appreciably increase the cost of nursing or other services and would satisfy the patient. It might slightly reduce bed capacity but would tend to increase the percentage of occupancy. These cubicles could be of light construction and should have opaque partitions, though a curtain could be used instead of a door. At Johns Hopkins one of the large wards has been treated in this way.

2. Offices, examining and treatment rooms, and telephone, secretarial, and bookkeeping services may be provided for members of the staff so that they may use the hospital and its facilities in connection with treatment of ambulatory as well as bed patients. Such offices should be rented to staff members either by the day or hour; they should not be donated. The resulting increase in use of laboratories and similar services would bring these adjuncts nearer to a capacity production basis, materially reduce unit costs, and so enable physicians to render better and more complete service to all of their patients. This is particularly important in view of the high unit costs today which make it impossible for physicians to employ laboratory services to the extent they would like and really need to use them.

The spaces allowed for offices would reduce the amount available for beds but would increase the percentage of room occupancy and yield to the hospital a more regular income than it has had from these rooms. Furthermore, the ready availability of hospital laboratory services and all specialists would make it unnecessary to admit as bed patients many now admitted for diagnosis, observation or education in dietetics. The hospital beds remaining after some space is converted into offices would be sufficient to care for those really requiring bed care.

Wider Use of the Hospital

The hospital would be used extensively not merely by surgical specialists, obstetricians and a few consultants in the medical field but by those who see the greatest number of patients — the pediatricians, the internists and the family doctors. The practitioners of medicine who see many patients in their offices but refer few to hospitals as bed patients would thus be even more productive for the hospital than are those specialists who have small office practices but now refer a high percentage of bed patients. Offices should also be provided for dentists in order that all ailments may be treated in the hospital.

Private rooms could easily be converted into offices. A private bath might be converted into a dressing room and if none exists a dressing or examining cubicle could be constructed. Members of the staff might be able to furnish desks, examining tables, chairs and other equipment for the offices, or these might be supplied by the hospital. Rents for furnished offices should be higher than for those unfurnished. A few rooms would have to be furnished as reception rooms and some provided for use of the stenographers and clerical help. It might be necessary to enlarge the switchboard. The rooms changed to offices should be selected because of their accessibility to elevators, laboratories and pharmacy. They should be separated from portions of the building used by bed patients so that ambulatory patients would not have to use corridors on which wards and private rooms open.

3. To be of more service as a medical center, the hospital should have a fairly large staff — much larger than the average staff today. The staff should be composed of qualified specialists in the various limited fields of practice, as at present, plus enough family doctors and specialists in family practice, to maintain a large volume of work.

Ten private rooms equipped as are rooms in the Mayo Clinic building would probably provide office

space for at least twenty-five physicians, some of whom might want rooms all day; a few others for three or four hours a day, but most of them for only one or two hours. A 150-bed hospital now only one-half full and rarely averaging 80 per cent capacity could convert as many as twenty-five bedrooms into offices thus making space available for fifty to sixty physicians, about one-half of whom should be specialists in limited fields, including dentistry, and the other half, family doctors.

The eighty-four voluntary and proprietary hospitals in Chicago with an average capacity of about 150 beds would on this basis provide offices for from 4,000 to 5,000 physicians and dentists — would just about provide offices for the members of the Chicago medical and dental societies.

Who Should Compose the Staff

The attending staff of a hospital should be composed of those qualified by national boards as specialists in limited fields of practice; of able and established specialists in family practice; of young physicians ambitious to qualify as specialists in one of these fields, and of dentists. If the hospital would follow the example of rental agents in new buildings catering to physicians, surgeons and dentists; persuade some of the key men on the staff to move their offices to the hospital, charging only for the service until their present lease expires; advertise to the rest of the staff, consulting, attending, associate, courtesy and assistant, that offices would be available at reasonable rates for all desiring them, there would be no difficulty in filling all available office space in a short time. As a matter of fact, enough leases probably expire on every May 1 to permit all such space to be filled in two or three years.

4. As Doctor Buerki suggests, there is no reason why the hospital might not make services available to all qualified medical men in a community whether or not they are active members of the hospital staff. Thus the outside doctors' patients might obtain services of the clinical and x-ray laboratories and physical therapy departments by appointment. Such use of service departments would result in their operation at capacity and so make possible a material reduction in the unit costs of services.

This plan does not make necessary the organization of a group. It does not make it necessary for the hospital as a corporation to enter the practice of medicine. But it does make of the hospital an institution or a plant in which all types of medical service can be furnished as efficiently and as economically by physicians, surgeons and dentists, as when their offices are not located in the hospital.

It would save the physician hours spent in transit between office and hospital. It would popularize the hospital with members of the medical profession and through them with the public. Some doctors fear that if they have been practicing in one hospital for a time and then find a change to another hospital advisable their patients will not follow them. However, if they have really been rendering service those patients who are worth keeping will follow them wherever they may choose to go.

Others in the metropolitan areas feel that their hospital is too far from the center of things or from the homes of their patients, yet when one of their patients is admitted to the hospital as a bed patient, members of his family manage to get to that hospital once or twice a day. It seems unreasonable to believe that an ambulatory patient could not get there once or twice a week or month to see the physician he desired to see. When he learns that the longer trip results in better service and at the same time lower cost, he certainly will cease to object. Furthermore, even in metropolitan areas, many physicians and surgeons with large private and consulting practices have always had offices in or near their hospitals or in residential areas.

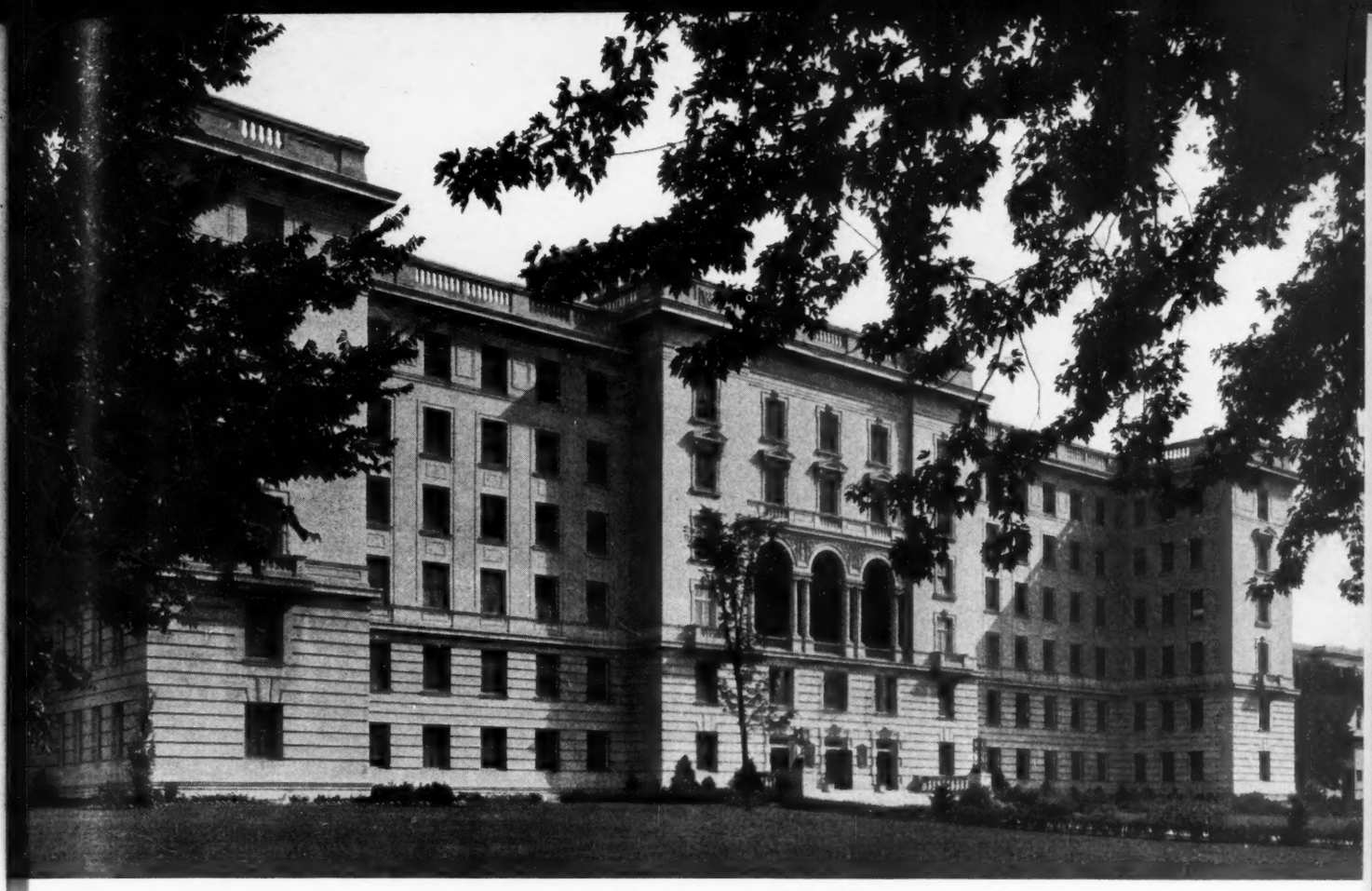
A hospital so organized would really be a center for medical service. It would cease to render fractional services and become what it was intended to be. Because it would be used to capacity, it would be operating more efficiently, costs would come down markedly all along the line, and yet accounting could be kept in the black. There is no doubt that such a development would do much to improve the quality of medical service without interfering in any way with the all important direct relation between doctor and patient.

Plans for Photomicrographic Dark Rooms

Suggested plans for two photomicrographic dark rooms have been prepared by Bausch & Lomb Optical Co., Rochester, N. Y. One of these plans calls for the smallest usable space, 6 feet by 6 feet, for which any small room or closet, or even the corner of a room, may serve the purpose. The other plan is for an average size dark room, 9 feet by 12 feet.

These layouts show the suggested arrangement of sink, safelight, shelves for chemicals, plates, films, paper, table, print washer and drain boards. Estimated costs for carpentry, painting, plumbing and electrical wiring are made. The customary materials needed for the dark room are listed and their total cost estimated.

The plans are printed on one side of a heavy cardboard poster, 9½ inches by 13 inches, on the other side of which the rules for using the dark room are printed, with a gold caption, "Knock Before Entering."



State of Wisconsin General Hospital, Madison.

A Nursing Curriculum That Broadens the Student's Background

By GRACE J. KELLOCK
Assistant Professor of Nursing, University of Wisconsin, Madison

NURSING, one of the youngest branches of education, has been working its way during the past three decades from the position of a trade to that of a profession. The curriculums have been changed many times in the effort to achieve this end. To a few lectures of a purely utilitarian nature have been added courses designed to broaden the scientific background of the student. This background has given her a more intelligent interest in the medical problems presented by the patient. More recently courses have been added to widen her social horizon and to broaden her knowledge of and interest in the world.

The school of nursing of the University of Wisconsin, Madison, has been in existence for ten years, a period sufficient to furnish the basis for a fair stabilization of its curriculum. It has always been an integral part of the university. Its students fulfill the same requirements for registration as students in the other schools and its faculty are appointees of the board of regents. In this way both faculty and students enjoy all privileges offered by the university.

The chief problem facing the director of a school of nursing is the selection of a curriculum that will most adequately meet the needs of a student. This selection is made more difficult by the multiplicity of courses available in any university. For the University of Wisconsin curriculum courses were chosen that would open up various fields of study, provide some scientific and sociologic foundation for thought and leave a margin of choice of subjects to the students.

The present curriculum includes the basic subjects required for any degree — English, foreign language, history or mathematics and elementary chemistry. In addition the student studies some sociologic and biologic sciences, and may choose for her major study any subject in the college of

letters and science, medical sciences or home economics. The course leads to a bachelor of science degree and certificate of nursing. A total of 129 credits is required for graduation. Thirty-five of these credits are given during the residential period. The student may select this residential period at the end of the first, second or third year, receiving the certificate in nursing at the end of her residential studies.

Deciding on the Sequence of Courses

It is well for the student enrolling in the university in nursing to have decided at what period she will take her professional courses. At whatever time these are studied the programs of the various students will in the end be comparable. The sequence of courses, however, is dependent upon the location of the residential professional period in relation to the remainder of the course. During the year preceding that in which she intends to enter upon her residential career the student enrolls for physiology and anatomy, bacteriology, elementary nursing and elementary dietetics. Since these subjects are so definitely preparatory for the professional period they should obviously immediately precede it.

The course in anatomy and physiology and that in bacteriology are given in the form of lectures and laboratory periods by the professors in the medical school.

The prehospital nursing course includes lectures in the history of nursing, practice in bandaging, hospital housekeeping and simple nursing procedures.

Dietetics covers a study of the principles underlying diet preparation, the writing of various types of diets and practice in the preparing and serving of foods. This acts as a basis for the more advanced study of diet in disease which is given during the period of residence.

The same scholastic standing required for university graduation — grade points equal to credits — is required for entrance to residence, with the additional requirement that the student shall have received a grade of at least "Fair" in the preliminary nursing course. In addition to the routine college entrance physical examination the student nurse, at the time she selects her resident period, is given a second careful physical examination in realization of the increased hazard of her work.

We expect our nursing students to benefit greatly by the present program of tuberculosis prevention and early detection being carried out by the student health department for all university students. Finally, those students who have shown themselves in these preliminary courses to have little aptitude for nursing are advised to transfer to the school in the university which seems to fit their individual needs the best.

During the residential period the Wisconsin General Hospital is used as the laboratory for the ward practice. In order that the reader may have a clearer picture of the student's place in the life of the hospital it may be well to devote space to a brief description of that institution, its personnel and its administration.

The Wisconsin General Hospital, which is under the control of the board of regents of the university, was built on the university campus in 1924 as a memorial to those who served in the World War. A corridor connects the hospital with the medical school and with the student clinic and infirmary. The hospital accepts all types of cases that can be benefited by care, including surgical tuberculosis, communicable diseases, neurologic and psychiatric cases, adult and children's orthopedic cases. Neuropsychiatry and children's orthopedics are housed in separate buildings adjacent to the main hospital. The total number of patients which may be accommodated in all units is between five and six hundred.

The medical staff of the hospital are all members of the faculty of the medical school. The student nurses are fortunate in receiving instruction from these specialists in their various fields. The atmosphere of the wards is distinctly educational. Doctors, medical students and nurses may be seen in groups discussing the patient with whom they have been in contact, watching an operation or making rounds in a ward. This academic environment has its effect on the activities of the nursing staff.

Large Staff of Graduate Nurses Needed

Since students in nursing carry so little of the load of floor duty a large staff of graduate nurses is necessary. This floor duty can serve as excellent "refresher" courses for these graduate nurses and may be supplemented by attendance at classes for student nurses. The forty-eight-hour week leaves ample time for nonprofessional interests. As a result a large majority of these graduate nurses are receiving some definite form of outside instruction. Music, art, athletic activities and vocational school classes are popular. The largest number, however, are enrolled in classes at the university. Those who wish to take heavier schedules of classes than is possible with the forty-eight-hour week are allowed to do twenty-eight-hour duty weekly at a salary of $30 a month, with board and laundry. Many graduates who had previously completed a three-year nursing course are thus enabled to finish their university courses with this financial assistance.

Into this hospital environment the student comes for her residential instruction and practice period of twenty-seven months. Each service is allotted a specific period of time. Classroom instruction is either correlated with or precedent to ward experience in that service. Each student has one month of evening ward practice (until 11 p.m.), and one month of night ward practice (11 p.m. to 7 a.m.) in a medical or surgical division. She may also have a short period of night duty in obstetrics when this service is of educational value to her. The students are assigned this night ward practice during the summer and Christmas vacations, which leaves their days free for rest. Each student is on ward duty forty-eight hours weekly, inclusive of all class hours.

In addition to the basic services of medicine, surgery, operating room, pediatrics and obstetrics, the student receives experience in eye, ear, nose and throat, orthopedic (adults' and children's), out-patient, communicable disease and neuropsychiatric nursing. Two weeks spent with the hospital social service department and six weeks with the city visiting nurses' association helps greatly in giving the student the broader social viewpoint which nurses so frequently lack. Since nursing is, or should be, preeminently educational in nature, an elementary course in educational psychology and teaching principles is given the student during her senior year by a professor in the school of education. This educational background finds expression in the teaching of patients, in the instructing of other nurses, or in bringing home to the lay public the broader rôle that nursing plays in safeguarding the public health.

During her years in residence the student lives in a dormitory for student nurses. All university social functions are of course open to her, as well as teas, dances and other parties given in the dormitory. Tea is served each afternoon of the school year in the dormitory lounge to students, graduates and staff members, by the students. The women's self-governing association of the university, of which all women students are members, governs the life and interests of the students in the dormitory.

When one considers that three years of experience in hospital duties were so recently devoted to work in only half-a-dozen departments, it is clear that the same period divided among upward of a dozen services cannot be expected to create experts in all these fields. The administrators of the school feel that the fundamental principles can be taught in a minimum length of time and that the student can gain her necessary practice in these various fields as a graduate nurse on salary rather than to be exploited as cheap labor. In accordance with this opinion, therefore, the period of experience offered in each service has been reduced to the amount considered necessary to provide a sound foundation for further study and experience. The aim is not to create a perfect nurse, but to provide the basis for continued growth in the art of nursing.

Liability of Charitable Hospitals for Unauthorized Autopsies

The liability of charitable hospitals for unauthorized autopsies was made clear in a ruling handed down by the Supreme Court on the Grawunder *v.* Beth Israel Hospital Association, 272, N. Y. S. 171. The case is outlined as follows in the *Journal of the American Medical Association:*

The plaintiff's husband died at eight o'clock one evening and the body was removed to the hospital morgue. The following morning at nine o'clock an undertaker, sent by the plaintiff, called for the body but was told by hospital authorities that it was not then ready for delivery. At two o'clock in the afternoon he was allowed to take the body.

Later it was discovered that an autopsy had been performed on the body, the vital organs removed and the space filled with cotton. The plaintiff, who had not authorized an autopsy, sued the hospital. The trial court gave judgment to the plaintiff after reducing the amount awarded to her by the jury.

The case then came before the supreme court of New York and the opinion handed down stated that a hospital should not be held as an insurer of the safety of a dead body in its possession, nor should it be held liable because of the mutilation of a body in its possession by any person or from any cause whatsoever.

The evidence in the case clearly showed that the body was mutilated while in the exclusive possession and control of the hospital. The plaintiff, of course, could furnish no proof as to who did the unlawful act. The defendant hospital disclaimed all knowledge of this particular autopsy and called attention to its rules concerning the performance of autopsies. These rules, however, were not observed or in force in this instance, and might have been nonexistent so far as the plaintiff was concerned.

The defendant hospital, which should have knowledge of all the facts, did not show that some person pursuing an independent calling and not acting under the authority or direction of the hospital performed the autopsy. The defendant alone knew what transpired within its walls during the night and morning following the death of the plaintiff's husband.

A hospital has the means to exercise control over what goes on within its building. Requiring it to take some precaution to prevent the unlawful mutilation of deceased patients is not placing an undue burden on it, and it should not be allowed to avoid all liability by professing ignorance of what has happened within its own confines. In view of all the facts, it was possible for the jury by reasonable inferences to find that this unlawful autopsy was performed by the direction or with the consent, knowledge or permission of the defendant hospital. The judgment in favor of the plaintiff was affirmed.

Editorials

Encouraging Hospital Research

THE tendency of hospitals to profit by the results of their own research is a strong one. Executives of initiative and ability are continually discovering new and efficient methods of performing their tasks. Here and there creditable research problems are being prosecuted along purely administrative lines.

True it is, that from various committees of the American Hospital Association there come highly worthwhile reports as to hospital record keeping, the best type of flooring, effective methods of housekeeping and practical economic procedures. Nevertheless, the institution conducting such types of research is too often content to profit by its own studies. This is not usually purely a matter of selfishness but rather a lack of appreciation of the needs of the field. Many hospitals are wondering, for example, why serious temperature reactions result now and then from the injection of salt solution but few executives have been competent or willing to undertake the serious study of such a vital problem.

Large endowment funds are not always necessary to discover better methods of administration. If hospitals would promptly publish the results of their experiments in searching for better methods, a composite would accumulate which would be of lasting service to the whole field. Research in hospital administrative problems should be encouraged and in order to bring this about prizes from time to time might be offered by national associations or foundations which would stimulate this type of contribution to hospital work. Good hospitals and good executives should not continue to hide their light under a bushel.

Securing Consent for Operation

A JUNIOR member of the surgical visiting staff of a large hospital in the East recently asked the administrator whether it would not be good practice to secure consent for operation routinely, in advance of the arrival of the operating surgeon, on ward patients admitted to the surgical service.

He had just been confronted with a situation in which he had come to the hospital at the request of the house surgeon, prepared to operate, and discovered on his arrival that the patient would not consent to the operation that had been prescribed for him. He argued that surgeons in such cases could be spared the trip to the hospital, since in this instance it was taken in vain. The answer was "no" — a patient should not be expected to consent to a major operative procedure until his confidence had been won for the operator and the operation. It must be remembered that the patient is engaged in a struggle for life and at the moment is under a decided handicap.

It is part of the surgeon's duty to convince the patient of the need for such radical treatment, and this cannot always be accomplished by deputy. The personal relationship between patient and operating surgeon is of incalculable value in the management of a surgical case. It would obviously be unreasonable, therefore, to expect a ward patient to submit to a major procedure on the demand of the house surgeon, capable and kind though the young doctor may be.

It is true that in the instance prompting the question the surgeon made a fruitless trip to the hospital. But the refusal of a patient, who needs a major surgical operation, to consent to it, if the need has been explained to him by the surgeon, is rare indeed — rare enough to make the kind of legislation requested arbitrary and harmful to ward patients in the long run.

An Enlarged Editorial Board

IT IS a pleasure to announce that four new members have been added to the editorial board of The MODERN HOSPITAL during the past summer and that John R. Mannix of Cleveland has agreed to act with Dr. R. C. Buerki as editor of the plant operation department of the magazine. The new editorial board members are Robert E. Neff, F. Stanley Howe, E. Muriel Anscombe and Dr. Lewis E. Jarrett.

Mr. Neff is administrator of the University of Iowa Hospitals and has long been numbered among the valued contributors to The MODERN HOSPITAL. As president of the American College of Hospital Administrators, he occupies a prominent place in hospital activities.

Mr. Howe, director, Orange Memorial Hospital, Orange, N. J., has originated valuable ideas of hospital administration. As chairman of the A. H. A. committee on workmen's compensation and liability insurance he did yeoman service to create a better understanding between hospitals and insurance companies.

Miss Anscombe needs no introduction. She is one of the outstanding administrators who came from the field of nursing. As superintendent of

Jewish Hospital, St. Louis, her effective work was on exhibit at the recent convention.

Doctor Jarrett directs the hospital division of the Medical College of Virginia. He is recognized in the South as an able administrator and a vigorous hospital leader. He was recently elected president of the Virginia Hospital Association.

Mr. Mannix, assistant administrator, University Hospitals, Cleveland, has long been identified with The MODERN HOSPITAL as a highly esteemed adviser and contributor. He has been diligent and effective in national and state hospital affairs for many years, and recently was president of the Ohio Hospital Association.

The Sick Employee

REWARD for a kind deed is a natural reaction throughout the biologic kingdom. The story of Androcles and the Lion is founded on a normal phenomenon which is characteristic of life generally. Kindness to subordinates, particularly when it is not stipulated in the bond, is returned many times over in service, and the hospital employee is no exception to this rule.

When a hospital employee is sick he is legally entitled to any benefit that his contract may confer on him. If he were working in a commercial establishment, he would in most cases have a limited period of sick leave with pay and in some cases hospitalization at reduced rates. The hospital employee, who is often underpaid in relation to the work that is expected of him, lives in an establishment where his care during illness is a matter of slight additional cost to either side.

If kindness to a healthy employee pays, how much more does kindness to a sick employee pay? The prevailing practice in some hospitals of charging employees a "nominal" or "cost" fee for hospitalization insurance, deductible on the pay roll, is a short-sighted penny-wise-and-pound-foolish way of improving the financial position of the hospital. It is done at the expense of the employee and overlooks another opportunity to create and maintain for the hospital a loyal and contented working group.

There are many perquisites which the hospital cannot afford to give its employees during these trying days of economic distress, because they are expensive in money. We have here, however, an opportunity to make a gift of something that costs the hospital relatively little and to receive in return faithful service that is out of proportion to the gift. As a member of the community, the hospital employee is, on final analysis, entitled to hospitalization of various grades, in accordance with his ability or inability to pay for it. How much in each individual case would this amount to in terms of money? Having calculated the figure, what does the financial committee of the board of trustees think of this investment possibility for the hospital? Calculations on the basis of general per capita cost, while indicating a figure higher than the actual additional cost of caring for sick employees, would still be worth considering in cases where a limited period of hospitalization is required. Hospitals are, indeed, compelled by law to compensate workmen who are injured while on duty. This belongs to the employee as his legal right. It is the additional kindness to him while he is otherwise sick that counts for so much in hospital management.

There is also a negative side of the picture. To turn away from the employee who is in need at a crucial period, unless he pays his hospital employer for interest in his welfare, is to invite hardships in labor turnover, service and loyalty.

What Is a Charitable Institution?

THE subject of taxation is rightfully uppermost in the minds of citizens in this country at present. The populace generally has become tax conscious. While all realize the necessity of taxation for the maintenance of government projects, the extension of taxation to religious, charitable and other organizations is being closely scrutinized.

The hospitals of the country are peculiarly proud of being denominated as charitable institutions. Nevertheless there are some who question their right to be so classed because of their receipt of fees for service rendered and since the property which they own is worth in total millions of dollars.

Generally, statutes of the various states definitely exempt from taxation institutions not conducted for profit. The receipt of pay from patients does not alter the hospital's charitable character. This is true because such funds, if devoted to the furtherance and purposes of the institution, cannot be classed as profit.

The fact that hospital benefits may be limited to a special class has also been the subject of spirited legal contests. If a hospital is not open to the public generally, but is conducted only for the benefit of a particular group, tax exemption has been refused in at least one instance. Yet there is another court decision to support the charitable nature of an institution open without charge to the whole public or to all of a class for whose relief it is adapted. A psychopathic, orthopedic or

children's hospital represents an example of this type.

Of the greatest importance from a legal standpoint is the motive underlying the conduct of a hospital. If the institution is conducted for possible private gain even though no profits ever accrue or if provision in any form is made for personal gain by trustees or others, charitable exemption cannot be expected. The fact that an institution is conducted by denominational or sectarian groups has been interpreted as not interfering in any way with its charitable character.

Legal decisions affecting the exemption of land employed for tennis courts, nurses' homes and hospital farms are important to many hospitals. In some states the number of acres exempted from taxation is definitely limited. This number ranges from five in New Jersey to 320 in Iowa.

Finally, any state indulges in a doubtful practice when it exacts a tax from a charitable institution on bequests for its future maintenance. Such a policy is certainly "robbing Peter to pay Paul."

Why Not Monthly Round Tables?

NO ACTIVITY of hospital conventions is more productive of practical good than the informal round table. Administrative knowledge cannot grow except by an accumulation of individual experience. Why should not a monthly hospital magazine represent a round table twelve times a year in which opinions are asked and given and in which the understanding spirit of informality is always to be found? The columns of this magazine are freely offered to the hospital field for this purpose. Who will contribute the first question?

What's in a Name?

THE Shakespearian injunction that the fragrance of the rose is not dependent on its name is no doubt applicable to many modern situations. The head of a hospital, for example, may represent the acme of efficiency and humanitarian achievement and yet be designated by any one of a half dozen titles today in more or less common use.

Should he be termed superintendent, director, administrator, executive or manager? Why is not there a greater uniformity of nomenclature throughout hospitals generally? Perhaps the pernicious insistence on individuality — the desire to be different — explains it. To some, the term "superintendent" appears undignified and smacks of the nomenclature of the manufactory or the prison. "Director" suggests to others a possible confusion with the term sometimes applied to a trustee. The term "executive" is, perhaps, inappropriate because it is often employed merely to indicate that an individual supervises the work of others.

To denominate a hospital head as its "administrator" is wholly dignified and fairly descriptive. To employ the term "manager" has a strong department store intimation. If the hospital head is medically trained he might be known as its "medical director and administrator." If he is not so trained, as "administrator." If the term "superintendent" is to be employed the former might be known as the "medical superintendent" and the latter as merely "superintendent." This distinction seems hardly to be recommended although to many it appears satisfying.

The hospital associations of Virginia, North and South Carolina recently voted to use the term "administrator," with such qualifiers as "and medical director" or "and superintendent of nurses," when appropriate.

To clarify the question, would it not be wise for a suitable committee of the American Hospital Association to suggest a nomenclature which might be generally acceptable?

Hospitals and the Housing Act

THE amendment to the National Housing Act which raises the limit for an individual loan to $50,000 now makes the act of definite value to hospitals. Elsewhere in this issue (page 71) Robert B. Smith outlines the provisions of the act as they relate to hospital modernization and improvement.

The act was originally designed primarily for small projects, and provision made for repayments of loans in small monthly installments. Because the handling charges on this type of loan are heavy the interest rate will be high — amounting under the act to a true rate of between nine and ten per cent.

This need not, however, alarm hospitals, or deter them from investigating the possibility of taking advantage of the new maximum. The interest rate may be lowered in the discretion of the banker, and should be lowered for large loans made on good security. Certainly a soundly managed hospital would be a good security for a loan to finance improvements in its services. The law of life is change; if hospitals do not go forward they will go back.

Housing Act Will Aid Hospitals

By ROBERT B. SMITH
Federal Housing Administration, Washington, D. C.

AID is now offered for the rehabilitation of hospitals of all kinds and in all sections of the country, through amendments to the National Housing Act. Government hospitals needing funds undoubtedly would have sufficient appropriations made by the government for their maintenance. Municipal hospitals might have recourse to the Reconstruction Finance Corporation, but any hospital whose credit rating is acceptable to an insured lending institution is eligible for modernization credit under the terms of the Act.

The rules governing the extension of credit and the procedure necessary are as follows:

The National Housing Act, functioning through the Federal Housing Administration, makes it possible for private lending institutions to release credit in amounts up to $50,000 until April 1, 1936, for the modernization of certain types of properties, including hospitals. These private financial institutions are insured by the Federal Housing Administration against loss up to 20 per cent of the total of all credit they extend.

The Federal Housing Administration lends no money. It is the means for bringing together those seeking credit for modernization and repairs and the private financial institutions having money to lend from their private resources.

Estimate of Work Must Be Submitted

In applying for funds for the modernization of hospitals, applicants are not required to have an account at the bank with which they propose to do business, but they will be expected to submit an estimate of the work to be done and a financial and credit statement. If the applicant is acceptable to the financial institution, and if the purposes for which credit is needed are eligible under rulings of the Federal Housing Administrator, funds should be forthcoming without delay.

Funds advanced must be used for the needs specified at the time of the negotiations and the amount must be repaid in monthly installments.

While $50,000 is the maximum amount allowed on each property, and five years is the limit of time for repayment of the loan, the lending institution and the borrower will decide in each case the amount of credit and the number of monthly installments in which the loan is to be repaid.

The carrying charges permitted by the Federal Housing Administration are at the lowest rates for this type of credit. The maximum must not exceed the equivalent of $5 discount per $100 face amount of a one-year note payable in monthly installments. Charges include interest, credit investigation, collection and bookkeeping incidental to payments made over a long period.

Maximum Loan Will Not Always Be Granted

Neither the lending institution nor the Federal Housing Administration will encourage the applicant to assume a greater obligation than he can reasonably carry. The applicant will not expect nor will he be granted the maximum amount of $50,000, unless it is justified by his credit rating, unless the locality in which he is operating shows signs of favorable growth.

Former restrictions as applied to lessees have been rescinded and lessees or tenants are eligible for modernization credit up to the new maximum on a basis equal to that of the owner upon proof of right of occupancy of the property.

Through the amendments to the act, passed in May, 1935, purchases and installation of machinery and equipment in properties listed in the $50,000 class are also eligible for modernization credit provided they are "peculiarly adapted to the business conducted therein or necessary to the operation thereof."

The amendments regulating the purchase of equipment do not include articles of too movable a nature, for instance, hospital beds are not eligible but x-ray machines, sterilizers, operating tables and many other articles in daily hospital use are on the approved list. The lending agency is ordinarily able to rule upon eligibility, but communication with the housing headquarters in Washington will bring advice upon specific cases.

Oil burners, kitchen ranges, water heaters, ventilating systems, plumbing fixtures and equipment, and other items may be installed through the application of modernization credit. Of all the recent aids to comfort, air conditioning should prove most acceptable to patients ill during hot summer days and nights.

Doctor Munger Chosen President-Elect

R. C. Buerki, M.D.

WITH a very large attendance, perfect weather, a splendid program and keen interest on the part of delegates, the thirty-seventh annual convention of the American Hospital Association and allied organizations was held in St. Louis, September 30 to October 4. A definite feeling of optimism reflected better conditions among hospitals.

Dr. Claude W. Munger, director, Grasslands Hospital, Valhalla, N. Y., was chosen as president-elect of the association and Dr. R. C. Buerki, superintendent, University of Wisconsin General Hospital, Madison, was installed as president.

Other officers of the A. H. A. are George D. Sheats, Baptist Memorial Hospital, Memphis, Tenn., first vice president; Edith B. Irwin, Westmoreland Hospital, Greensburg, Pa., second vice president; Dr. Albert W. Buck, New Haven Hospital, New Haven, Conn., third vice president; Asa S. Bacon, Presbyterian Hospital, Chicago, treasurer; Dr. B. W. Black, Alameda County Institutions, Oakland, Calif., and E. Muriel Anscombe, Jewish Hospital, St. Louis, trustees. All the officers are superintendents of their respective hospitals.

Hardgrove to Be on A. H. A. Staff

Dr. Bert W. Caldwell, executive secretary of the association, was chosen by the trustees as editor of the official publication of the association. Arden E. Hardgrove, superintendent, Akron City Hospital, Akron, Ohio, and for several years executive secretary of the Ohio Hospital association, was chosen as assistant executive secretary of the American Hospital Association to relieve Doctor Caldwell from some of his many duties.

Meeting simultaneously with the A. H. A. were the American Occupational Therapy Association, the National Association of Nurse Anesthetists, the Children's Hospital Association of America and the Missouri Dietetic Association. A large number of state associations held breakfast or luncheon meetings.

The 1935 National Hospital Day award was presented by Albert G. Hahn, chairman of the committee, to the Lutheran Hospital, Brooklyn, N. Y., of which Augusta E. Abel is superintendent. First honorable mention went to Newton Memorial Hospital, Newton, N. J., of which Charlotte Janes Garrison was superintendent. The committee found it so difficult to make a choice between these two institutions that it recommended that hereafter there be two classes of awards, one for hospitals in cities of 15,000 population and over and the other for hospitals in smaller places. Special tribute was paid to the late Matthew O. Foley, founder of National Hospital Day.

Hospital Day Honors

Other honorable mentions were given by the committee to Staten Island Hospital, Tompkinsville, N. Y., Louis H. Putnam, superintendent; Wesley Hospital, Wadena, Minn., Madell Motsiff, R.N., superintendent; Middletown Hospital, Middletown, Ohio, Ada J. Leonard, R.N., acting superintendent, and Saginaw General Hospital, Saginaw, Mich., Mrs. Kate J. Hard, superintendent.

The banquet and ball in the Hotel Jefferson was attended by the largest group ever to join such a function at the A. H. A.

The relations of hospitals to government agencies occupied a prominent place on the program. President Jolly berated the federal government for its failure to come to the aid of hospitals and for competing with voluntary hospitals in various ways. The same theme was followed by Senator Bennett Champ Clark in addressing the banquet and by Dr. Nathaniel W. Faxon, Boston, in a discussion before the social service section. On the other hand, Dr. C. H. Lavinder, medical director, U. S. Public Health Service, Washington, D. C., declared that two cardinal principles of public health are that the care of the sick is a local problem and that the provision of medical relief is not a public health responsibility.

Two resolutions of the association dealing with this problem were presented. The first instructs the joint committee on federal legislation to continue its endeavor to obtain federal funds to pay for hospitalization of people on relief or work projects when their total income is insufficient to meet these costs.

An Important Resolution

The second resolution recommends that state and local hospital associations encourage the enactment of state welfare laws which will recognize medical and hospital care as integral elements of relief and require local governments to furnish such care to sick persons who are unable to provide it themselves. This resolution also calls to the attention of the hospital associations the practice of using local voluntary hospitals for this purpose and recommends the extension of this policy in cities and counties in which it is not yet adopted.

Group hospitalization attracted a great deal of attention among the delegates. A resolution passed by the association recommended that hospitals contemplating the establishment of or participation in group hospitalization plans bear in mind the recommendations of the A. H. A. and consult the offices of the association for information and advice concerning the sponsors.

The new manual of hospital accounting and statistics was discussed in a round table which overflowed the hall in which it was held. A resolution was passed by the association calling on hospitals to adopt the recommendations embodied in the new manual.

Another resolution requested the president to appoint a committee to study the operation of hospital pharmacies and develop minimum standards for them.

The question of hospital supplies was dealt with in a fifth resolution which urged manufacturers and wholesale distributors to take all possible precautions to see that their goods are marketed through distribu-

Large attendance and exhibit feature A. H. A. convention... Hospital Day award goes to Brooklyn... Relations to government extensively discussed... New membership plan proposed ... Group hospitalization interest widespread

C. W. Munger, M.D.

tors who realize their responsibilities and have knowledge and experience sufficient to enable them to appreciate the needs of customers and whose statements shall truly represent the quality and usefulness of their wares.

Reorganization of the membership basis of the association was recommended in a report by the "Committee to Adjust Membership Regulation," which was headed by John R. Mannix, University Hospitals, Cleveland. The committee recommended that active membership should be limited to hospitals and related institutions and that allied membership should be available for associations of denominational, racial and special hospitals or hospital professional groups.

Affiliate membership should be available to medical, public health and educational associations and to interested foundations. Associate membership should be for other interested associations. Active personal membership would be limited to persons associated with active institutional members except that it would also be available to executives of government hospitals which because of legal restrictions cannot become institutional members. Associate membership would be provided for others with the provision, however, that in the future no one could become a personal member unless his hospital is an institutional member if eligible.

Active institutional members would be entitled to one delegate for each 10,000 days of patient service with a maximum of six. The committee also recommended that except for national organizations membership should be conditional upon approval of an organized state or provincial hospital association if such exists.

The committee also recommended that dues of active institutional members be one mill for each day of patient service with a minimum of $10 and a maximum of $100.

The relations of the A. H. A. to state and provincial associations were also studied by the committee which recommended that action be deferred till next year.

The report of the legislative reference committee and that of the council on community relations and administrative practice, both of which were presented at the same session, attracted a very large attendance. The committee on legislation reported that the weekly legislative bulletins had proved very helpful to officers of local hospital associations and recommended that this service be continued.

The most important subject of legislation, the committee stated, was the national Social Security Act. A. M. Calvin, chairman of the committee, said that hospitals had been exempted from the taxes and hospital employees from the benefits through the action of the joint committee in Washington. On the other hand, he stated that plans for voluntary old age annuities for hospital employees are being developed by the national government. This plan would permit a maximum annuity of $100 a month.

Mr. Calvin also reported an agreement with the Works Progress Administration to pay voluntary hospitals $4 a day for the care of employees protected by workmen's compensation under the WPA. This is similar to the CWA plan but a higher rate.

Community and Financial Relations Are Major Topics for Discussion

THE relations of hospitals to their communities and to their legislatures and the developments in group hospitalization were major subjects at the convention.

In spite of the resolution of the Philadelphia convention last year urging hospitals to turn to local governments for financial support for meeting the cost of caring for indigents, there still seemed to be some divergence of point of view. Senator Clark, the banquet speaker, expressed his opposition to the stand taken by the federal government and declared that it would be his purpose to get financial assistance from federal funds for hospitals. Others seemed to feel that this policy would be fruitless or was unsound.

Edith Foster, regional social worker, FERA, Chicago, declared that it was a wise decision to separate hospital care from other relief needs for this released funds that communities would otherwise have had to spend for food, clothing, rent, or fuel and allowed it to be used for hospital care. Furthermore, she pointed out, it meant that when the emergency is over and federal relief funds are withdrawn, there will be less upset to hospitals.

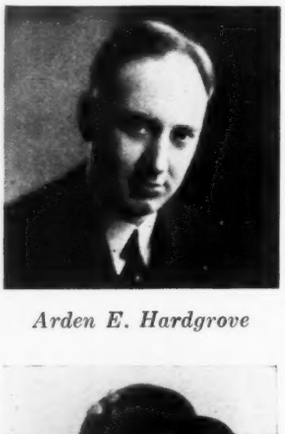
Now that the federal government is trying to move 70 to 75 per cent of the people from relief rolls to WPA payrolls, Miss Foster said, the medical profession is wondering what will happen to medical care for these people. Small families might be able to pay for medical care out of the "security wage" of $52 a month but large families obviously could not.

The need of better relations between government and voluntary hospitals was stressed by Dr. S. S. Goldwater, commissioner of hospitals, New York City, and Dr. Michael M. Davis, Julius Rosenwald Fund, Chicago.

Both speakers emphasized the importance of good organization and reduction in political interference. Doctor Davis pointed out that political mismanagement in government hospitals has a vital effect on their voluntary neighbors. Improvement of administrative standards in the former will lessen their competition with the latter, he said. He also pointed out that paying patients in local government hospitals are becoming increas-

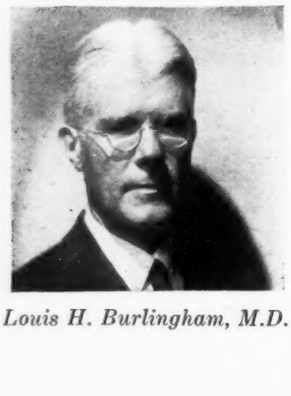
ingly frequent, an indication that these hospitals are becoming real community institutions. The public cannot get along without voluntary hospitals, however, Doctor Davis declared, mentioning that many communities have only voluntary hospitals to serve them. Furthermore, he said, the government agencies have not yet fully met their obligations in the provision of mental hospitals, tuberculosis hospitals and, particularly, hospitals for chronic cases. These are well accepted public responsibilities.

At another meeting the association went on record in support of nonpolitical administration of government hospitals. The resolution pointed out that the A. H. A. has always been unalterably opposed to corrupt political manipulation of hospitals because of the calamitous effect on services affecting the lives of indigent sick who are helpless to protect themselves. The report proceeded to commend the mayor of New York City for his declared intention of removing partisan political interference and corruption from the New York Department of Hospitals and his courageous appointment of a commissioner of hospitals of national reputation, proved ability and sterling integrity.



Arden E. Hardgrove

Mabel W. Binner



Louis H. Burlingham, M.D.

After congratulating the mayor for his commendable stand in this vital phase of public service, the association expressed the hope that this precedent established in the largest city may serve as a worthy example to other public officials charged with authority over government hospitals.

The demand from medical staffs for compensation for their services in free clinics, especially those of municipal hospitals, has become insistent in New York City, Doctor Goldwater declared. At first the demand was merely from the younger, less experienced men but more recently it has been endorsed by leaders in the senior attending staff, he said. It is being pushed so vigorously that it will probably soon become acute in other cities.

A hopeful view of the future of the voluntary hospital was expressed by Doctor Goldwater. He pointed to payments from tax funds and receipts from group hospitalization as new sources of support. New York City for many years has paid voluntary hospitals for the care of indigent city cases, payments which now aggregate millions of dollars.

Hospitals welcome the development of public health departments under the Social Security Act, said Robert E. Neff, University of Iowa Hospitals, Iowa City. The health officer can become a coordinating official to whom we can turn for help in meeting our problems, he stated. He called upon hospitals to supply care for communicable disease as their contribution to public health.

In discussing the "widening horizons" of public health under the Social Security Act, M. Antoinette Cannon, instructor of medical social work, New York School of Social Work, New York City, outlined five steps that could be taken under the act to make it most helpful. These are: (1) allocate funds both on basis of need and on basis of reward of merit; (2) encourage states to improve rural health programs; (3) administer medical relief by medical organizations rather than social agencies; (4) use federal aid to meet the problems of transients and nonresidents; and (5) redistrict the country for health because the county is so poor a unit usually for health administration.

Asked to elaborate her third point she declared that the agency with the purse strings controls policy. If this is a social agency it may employ a physician to guide its policy but it is primarily set up for social administration and often doesn't understand all the implications of its decisions on medical questions.

The federal government frequently makes a mistake when it steps in to support local agencies in emergencies, declared Dr. C. H. Lavinder, U. S. Public Health Service, Washington, D. C. It attempts to assume control when it does not know the situation nearly as well as the local agencies that have been handling it for years.

G. Harvey Agnew, M.D.

John R. Mannix

Mrs. Gertrude L. Fife

Any hospital, voluntary or governmental, which accepts indigent patients and receives a subsidy in consequence, is entitled to a grant equal to that of any other similar hospital of the same class, declared Dr. G. Harvey Agnew, secretary, department of hospital service, Canadian Medical Association, Toronto.

In Canada the payment of municipal grants is made obligatory upon the community by the province and in some cases the provincial grant is dependent upon at least an equivalent amount being paid by municipalities. This plan minimizes delay in hospitalization, promotes the development of voluntary hospitals and provides uniformly good care for the indigent, Doctor Agnew declared.

The opportunities for community service by small hospitals are almost unlimited, if one is to judge by the address of Dr. A. F. Branton, Willmar Hospital, Willmar, Minn.

Among the two dozen ideas listed by

Doctor Branton were the following: cooperation with lay organizations dealing with health matters; teaching maternity and other patients the elements of personal and family hygiene; promoting a good auxiliary; developing group hospitalization in rural areas; rendering assistance at clinics run by other agencies through loaning specialized personnel; giving laboratory service to ambulatory patients; developing staff good will through dinners and other means.

He also recommended training girl scouts in first aid, bed making and home care of the sick, demonstrating the scientific equipment of the hospital to high school science students; providing a free nursery at county fairs where mothers may "park" their babies; preparing and serving special diets to business men with diabetes and similar conditions; obtaining books for patients through the local library; offering to weigh babies without charge for any mothers and using that opportunity to advise mothers to consult their physicians; acting as a depositary for vaccines, for the state board of health; testing milk for the city; providing guest accommodations for patients' relatives; selling supplies such as nursing bottles, nipples, baby soap and other articles that relate to medical care or maternity service; organizing the doctors and nurses of the community to meet catastrophes and providing headquarters for health agencies of the community.

The only major session of the convention devoted to group hospitalization was a meeting called by Dr. C. Rufus Rorem, A. H. A. consultant on group hospitalization, for the executives of group hospitalization associations. About forty were expected and over 250 attended necessitating the moving of the meeting to a larger room.

Twelve different group hospitalization projects were briefly described by the executives representing each of them. From their reports it was learned that membership in these various plans was as follows at the time of reporting:

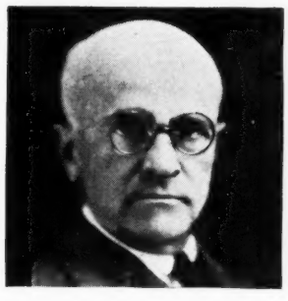
Baylor University Hospital, Dallas, Tex., (single hospital plan), 20,000 plus 3,600 dependents; New York Metropolitan area plan, 24,320; Cleveland, 13,322 plus 622 family members; Sacramento, Calif., 8,000; St. Paul and Minneapolis, 7,000 plus some dependents; Essex County, N. J., 6,400 contracts covering over 7,000 individuals; Rochester, N. Y., 16,000 subscribers; North Carolina, none (just starting); Youngstown Sheet and Tube Company, Youngstown, Ohio, (single company plan with free choice of hospitals), 11,576; Goodyear Tire and Rubber Co., Akron, Ohio, (single company plan), 20,000.

Dean Turner of the University of Illinois, Urbana, Ill., described the plan for group hospitalization of college students which that institution has been running for thirty-five years. It is voluntary on the part of students and faculty members, the cost being $3 a semester ($6 a year). Last year the receipts were $26,000 and the payments under the plan $24,000. Each year $3,000 is saved as a surplus for the following year and any money left over above that amount is spent on improvements in the university hospital. The limit is twenty-eight days and the average stay is 4 1-3 days.

Doctor Rorem reported that plans are now in operation in fifty cities and

J. V. Buck

C. Rufus Rorem



Willard Bartlett, M.D.

have 250,000 subscribers. Single hospital plans, he reported, are not flourishing. In most of the cities where plans are under way serious attention is being given to the protection of dependents. This is being done in three ways: (1) automatic inclusion of dependents without extra fee who are then given a 25 or 33 per cent discount; (2) inclusion of dependents at a small additional fee for partial coverage; (3) inclusion of dependents at full fee for full benefits. He recommended that during an experimental period the dependents should be only partially covered.

Administrative Topics Arouse Interest

THE agitation by radiologists to be put exclusively on a private fee basis has been carefully considered by the section on administrative practice under the chairmanship of Dr. R. C. Buerki. In conference with a group of distinguished radiologists, who however do not claim to act as representatives of the specialty, the section has formulated guiding principles which should govern the relations of hospitals to radiologists. These are:

1. The hospital should not be expected to operate its radiological department at a deficit.

2. The radiologist should receive decent compensation for his work.

3. If the above two principles are followed and the department still produces a balance, the benefit should go to the patients.

If these three principles are pursued the council holds that it is a matter of indifference to it whether the radiologist is remunerated on a salary, a fee basis or some combination of the two. In presenting this statement Doctor Buerki emphasized that the agreement had no official status but showed a growth of mutual understanding and confidence.

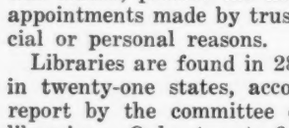
Doctor Buerki also reported on the work of the Advisory Board of Medical Specialties and recommended that hospitals help by publicizing the work of the board, that they seriously consider requiring in the future that all chief appointments on the staff be required to have certificates of the board; that in the appointment of younger men to the staff they take into consideration whether they will become eligible for certification by the board; and that hospitals approved for residence in specialties meet the requirements of the various specialty boards. The provisions of the board are scheduled to be put into effect provisionally in 1938. The work of the board, Doctor Buerki said, is the most significant step toward improving medical care of the last decade.

A hospital council is an organization broadly representative of community interests, including superintendents, trustees, staffs and the interests of the community at large, said Mary Hicks Bachmeyer, reporting for the council on community relations and administrative practice. They should be distinguished from superintendents conferences and regional associations which take in more than one community. New councils are in course of organization in New York City, Philadelphia and Chicago, she reported. The council recommended that each state hospital convention have a discussion on hospital councils.

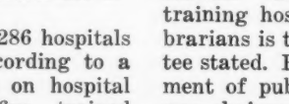
A system of regulating staff appointments and promotions through the organization of a national board of

standards in staff organization, was proposed in a report of the committee on nomenclature in uniform staff organization. This national board as described resembles the Advisory Board of Medical Specialties which is already in existence. Such a board would, it was stated, protect the hospital from appointments made by trustees for social or personal reasons.

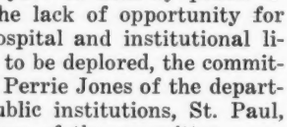
Libraries are found in 286 hospitals in twenty-one states, according to a report by the committee on hospital libraries. Only twenty-five trained librarians were found in these 286 hospitals, however. The above figures do not include state or federal hospitals. In 172 state hospitals for the insane were found 104 with some kind of book service and twelve with trained librarians, some of whom, however, were employees of near-by public libraries. The lack of opportunity for training hospital and institutional librarians is to be deplored, the committee stated. Perrie Jones of the department of public institutions, St. Paul, was chairman of the committee.



Fraser D. Mooney, M.D.



Frank C. Rand



Rev. John G. Benson

Hospital Building and Air Conditioning Are Discussed

THE reviving interest in hospital building was indicated by a good attendance at the construction section. Air conditioning, painting, elevators, and hospital lighting were discussed as well as the general conditions under which hospitals should build.

The committee on hospital planning and equipment departed from the usual type of report and discussed methods of computing a community's need for hospital facilities. It criticized the commonly used ratio of five beds per 1,000 population for cities and proposed a new set of ratios. The new ratios are five beds per 1,000 of the city's census for large metropolitan centers having general multiple housing, extensive suburbs and nationwide medical prestige; four to five beds for cities which serve as medical centers for extensive districts and suburbs not adequately self-hospitalized; three to four beds per 1,000 for smaller cities, and up to one bed per 1,000 for rural districts.

The committee suggested that these ratios be used only to suggest and not determine bed quotas. In the light of present overhospitalization the committee recommended that future expansion be intelligently and rigidly controlled and a "certificate of necessity" issued by some authoritative body after a careful study of the resources and needs of the community.

In discussing the paper Dr. Arthur C. Bachmeyer, University of Chicago Clinics, said that he was not sure that the committee's new ratios were better than those previously used.

Air conditioning has moved from the theoretical to the practical stage, reported the committee on this subject, and several hospitals have or are making, limited installations. Interest in the subject seems countrywide, they reported, with especial interest by hospitals in southerly latitudes. The committee repeated its warnings of last year that air conditioning of entire buildings is still too expensive for hospitals and that no ideal system has yet been devised. The committee also warned that air conditioning without suitable and effective insulation was wasteful. For operating rooms the committee recommended a system that would maintain a relative humidity of 55 per cent and a temperature of 80°F. with slightly higher temperatures on very hot days. The committee also recommended that systems should be used which have refrigerating equipment built for ordinary summer weather but which can be supplemented for the few excessively hot days.

A comprehensive discussion of hospital elevators was presented by H. Eldridge Hannaford, Samuel Hannaford & Sons, architects, Cincinnati. The selection of elevators should be based on a thorough analysis of the types of service they are to render, Mr. Hannaford declared. In the small institution this will usually mean only a passenger and a service elevator. In large buildings, however, separate provision may need to be made for food service, use of physicans and other employees and for express service to upper floors.

Elevators should be grouped in batteries to facilitate repairs, handle accidents and economize on salaries of operators, he said. The lifting capacity and speed should be governed by the nature of the service but for reasons of economy should not be faster or larger than is required. Although high speed elevators are not necessary except for express service there is nothing more annoying, Mr. Hannaford declared, than a slow elevator.

Many of the "hospital hazards" discussed by Dr. L. A. Sexton in a paper read for him in his absence had to do with construction. Doctor Sexton warned against anesthetic gases, refrigeration gases, oxygen tent explosions, fires and accidents due to faulty electric appliances, lack of sufficient fire prevention and control devices, lack of window protection for psychopathic patients, lack of emergency lights in the operating room, waxed floors, blind swinging doors, slippery stair treads, unfenced roof gardens and plumbing cross connections.

The hazards of plumbing cross connections were also discussed by Major Joel I. Connelly, Board of Health, Chicago, whose article on this subject appeared in the July issue of The MODERN HOSPITAL.

A feature of the educational exhibit was an extensive collection of floor plans of St. Louis hospitals, already built, under construction or proposed.

Miss Allen Speaks on Social Service Work

It is the responsibility of the hospital to know whether the housing conditions will interfere with the post-hospital care of patients and if so to adjust the situation somehow before the patient is discharged, declared Kathleen Allen, director of social service, Provident Hospital, Chicago. "Patients' diets should be watched, especially now with the wholesale transfer from relief to WPA. Wages must many times be supplemented to get good diets. This money should come from tax funds but if it does not then the hospital must find ways to help."

Miss Allen recognized that many small hospitals cannot afford to employ a full-time trained medical social worker. In such cases she suggested sharing a good worker with another hospital.

Child Hospital Workers and Librarians Meet Profitably

CHILDREN'S hospitals even more than others have suffered from the effect of disturbed economic conditions, according to Robert E. Neff, administrator, Iowa University Hospitals, Iowa City, Iowa. Philanthropy bestowed by many upon this appealing and popular phase of hospital work has been cut substantially. On the other hand, the hospital must keep abreast of new developments in medical science and must maintain certain standards. The threatened shortage of nurses particularly in such a specialized field as children's work is one big problem which administrators will be called to face, Mr. Neff feels. Need for specialized training to supervise efficiently every department is essential.

Robert E. Neff

Perrie Jones

There is nothing in the social service program as it applies to children's hospitals which reacts against any economy measures instituted by the hospital administration. Lelia I. Dickinson, head worker, pediatric service, Washington University Clinic and Allied Hospitals, St. Louis, emphasized this point in discussing social service problems in children's work. Many children can be kept out of the hospital through the proper kind of social service work in the out-patient department. Another important point in Miss Dickinson's paper was that the responsibility of describing accurately to parents the true condition of the child suffering from a chronic disease should rest with the medical staff.

Discuss Convalescent Child

Too often play in a children's hospital is something tacked on after the medical treatment, according to Ann M. Smith, director of children's play, Children's Memorial Hospital, Chicago. The picture is generally one in which some volunteer worker is seated alongside the bed, reading from a story book. There must be a fundamental approach, she urged, so that the disabled child can be kept occupied and interested.

The conduct of a convalescent department of a children's hospital formed another important topic around which much discussion centered. Those types of diseases which are eligible for convalescent care were carefully considered. A hospital connection is essential to the efficient conduct of a convalescent department to assure prompt care in the event of sudden illness or accident. Dental service is also a requisite. Visiting days constitute a problem and can be regarded only as a necessary evil. One day a month is the rule observed in one institution, and three days are generally required to offset the handicaps thus inflicted, according to the statement of the administrator.

Better Library Service

Comparatively few public libraries are providing good hospital service. This fact was emphasized by Charles H. Compton, assistant librarian, St. Louis Public Library. Libraries have suffered severely because of depressed conditions and whereas there is little immediate hope for development of such service because of inadequate finances with which to carry on he feels confident of ultimate expansion. In the meanwhile he recommends educating the hospital administrator, the physician and the nurse as well as the librarian on the value of hospital library service.

Much of the discussion on hospital libraries centered about the need for trained people to administer such service to hospitals. Not only does this entail close knowledge of books, but also the ability to fit the book to the patient. The application of libraries to two distinct types of hospitalization was studied — first as it has to do with psychiatric research and, second, its relationship to a children's hospital. Dr. M. C. Petersen, assistant superintendent, St. Peter State Hospital, St. Peter, Minn., discussed the first, and Marie Rainey, librarian, Gillette State Hospital for Crippled Children, St. Paul, Minn., described the functions of a school library in a hospital.

The committee on hospital libraries reported in this connection that several years ago in Minnesota a course of training for hospital librarians was worked out at the library school of the university. This course was to cover a full year but was found to be too ambitious.

In covering the general subject of hospital library service the practical side of the picture was not overlooked. The costs entailed were described by Robert E. Neff, administrator, State University of Iowa Hospitals, Iowa City, Iowa. Mr. Neff stressed the burdens which every department of the hospital is obliged to face during present times, making difficult the development of service not directly associated with the medical and surgical treatment of the patient.

Meeting of Mechanical Divisions Worth While

THE care and preservation of plumbing and sterilizers, problems pertaining to the power house and laundry, how to secure best results in painting — these were major topics presented for discussion on mechanical divisions of hospital operation.

No general formula for laundry procedure is possible, according to H. F. Neumann, of the Colgate-Palmolive-Peet Co., so much depends upon individual problems. However as he proceeded to point out there are certain rules which constitute good standards and which if followed closely will achieve economies. First, good quality linens should be purchased. Then, extreme care should be exercised in compounding alkalis properly and selecting other materials. Third, the condition of the equipment should be closely watched and frequent inspection made.

Hospital paint must be made foolproof, according to J. T. Lawrence of the Mitchell-Rand Co., Jersey City, N. J. It is not always handled by experienced people, and, too, it is subjected to harder use in hospitals than elsewhere. Three points should be considered in purchasing paint, first, quality; second, ease of application, and third, the standardization of color.

An important contribution was a treatise on the power plant, refrigeration system and laundry of the Cincinnati General Hospital, Cincinnati, presenting data acquired through a seven-year fact-finding campaign conducted by the mechanical department of the institution.

The care and preservation of plumbing and sterilizers from the viewpoint of economy was discussed by L. B. Stine of the Crane Co., Chicago, and William H. Driscoll, vice-president, Thompson Starrett Co., New York City, stressed the value of installing indicating and recording instruments in the power house.

Dietitians Talk Administration, Food Service and Research

TO ASSUME the rôle of executive of her department the hospital dietitian must be a true administrator, qualified by nature and by training to handle every phase of food service. More than one speaker at the dietetic session voiced this thought. Much real progress, it was indicated, is being made in the opportunities provided for younger women entering the field for more thorough knowledge in institution management, in addition to prescribed training in dietetics. The hospital administrator, too, is gradually recognizing the importance of the dietetic department and the need for its proper supervision.

A change in attitude on the part of hospital superintendents toward the dietitian was aptly described by Katherine Mitchell, president, The American Dietetic Association and dietitian, Michael Reese Hospital, Chicago: "She first entered the front door as a luxury, but has steadily worked her way to the back door." Two persons are generally considered qualified to handle food in hospitals, Miss Mitchell finds, one with hotel experience, and the other a dietitian. "The first can handle food for well people, but possesses no training for catering to the sick. Therefore if a hotel person is engaged, the services of a dietitian are also required."

Finding Food Costs

Miss Mitchell described the dietitian as closely tied in with all hospital interests — with the work of the medical staff, with the educational program, but particularly with hospital administration, in that she is an important factor in community satisfaction. Less vacillation on the part of the hospital superintendent as regards his food department, and greater knowledge on the part of the dietitian, particularly as applied to food costs, was Miss Mitchell's plea.

A system of food cost finding and control as worked out successfully at the New York Hospital, New York City, was outlined by S. Margaret Gillam, head of the department of nutrition. Miss Gillam stressed the importance of having everything placed before the chef, so that he may know that the food is there in the exact amount required for the day. Record cards which supply complete information on each individual employed by the department is an interesting feature of Miss Gillam's system. These follow the employee around, from one assignment to another, showing whether his salary has been increased or whether he has been discharged. Such information is particularly valuable in determining budgets, according to Miss Gillam. A high turnover in a certain job may indicate the necessity for raising the pay. "Food cost accounting need not be the complicated task it seems," she emphasized. "Each operation builds on another, thus providing the complete picture."

Overemphasis on Clerical Work

A warning lest clerical work in the dietetic department be carried on at a sacrifice of more important matters connected with its supervision was included in E. Muriel Anscombe's remarks on what the superintendent expects of the administrative dietitian. As administrator of the Jewish Hospital, St. Louis, Miss Anscombe contributed the point of view of the hospital superintendent. "Results obtained in the dietary department depend upon the extent of interest which the superintendent displays in that department," she said. In selecting a suitable dietitian the administrator should first become acquainted with the standards set by the American Dietetic Association, and should adhere to them, she believes. Second, the type and character of the hospital in which the dietitian took her student training should be investigated, and third what positions she has occupied since finishing her training and her tenure of office. One criticism voiced by this speaker is the tendency to sacrifice the art of food to the science of food.

The hospital as a teaching agency can contribute much to community health, according to Ethel Ollis, the retiring president of the Missouri Dietetic Association. The information it supplies must be effectively presented, however, with the doctors, nurses and the dietitian as teachers. The facts must be gone over again and again, Miss Ollis emphasized, to impress upon the individual the importance of food values. She also urged the use of the general diet in educating the patient regarding his food requirements.

Lenna F. Cooper

E. Muriel Anscombe

Facilities for Research

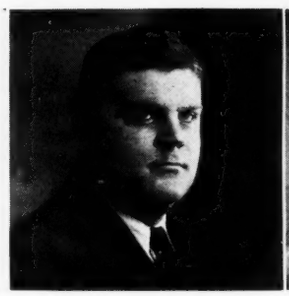
The dietetic department should serve as a research laboratory, affording a wealth of material on which to base all manner of scientific studies, according to Edith R. Tilton, Barnes Hospital, St. Louis, the incoming president of the Missouri Dietetic Association. This should produce, she believes, a vast fund of helpful information on such matters as the selective or nonselective diet and food waste.

The question of selective menus was discussed by Mrs. Gladys Hall Silkey, St. Louis University Hospitals. This type of food service is used in both units of this institution, one of them a hospital for private patients, and the other accommodating free patients. Although the case for the selective menu is a strong one, promoting satisfaction on the part of the patient, Mrs. Silkey believes that the argument that it reduces food waste is still debatable, not having been conclusively proved. On the other hand the selective menu has been found to provide all manner of opportunities for arousing the interest of the patient in his food problems, even to helping educate him in the proper selection of dishes. It is necessary to have the close cooperation of the nursing department, she believes, unless the dietetic department is sufficiently large that members of its staff can work with the patients.

Service for Ward Patients

Another subject considered was that of central ward service for ward patients. Louise Wilkonson, St. Louis County Hospital, St. Louis, described exactly how it functions in that hospital.

As part of the business routine Kate Daum, director of nutrition, University Hospitals, Iowa City, Iowa, was elected chairman for next year of the dietetic council of the American Hospital Association, succeeding Lenna F. Cooper, Montefiore Hospital, New York City.



Blanche Pfefferkorn, R.N. *A. F. Branton, M.D.* *Mrs. Ada R. Crocker, R.N.*

Nurse Group Considers Care, Costs, Supply and Training

THE section on nursing of the council on community relations and administrative practice reported that the manual on "Essentials of Good Hospital Nursing Service" was in the final stages and would soon be published. This manual has been prepared for a 150-bed hospital and represents agreements between the hospital group and a cooperating committee from the National League of Nursing Education. Dr. C. W. Munger, president-elect of the association, was chairman of the committee representing the hospitals.

Seven Educational Problems

In another meeting Dr. N. W. Faxon, superintendent, Massachusetts General Hospital, Boston, declared that seven problems of nursing education faced the hospitals and nursing schools. These are:

1. To balance the education value to the nurse against the service of the nurse to the hospital.
2. Properly to instruct nurses so they may adequately serve their communities in various fields of nursing.
3. To improve the organization and financing of nursing schools.
4. To eliminate inadequate schools.
5. To maintain an economic balance between cost to the nurse of her nursing education and her income as a nurse.
6. To control the oversupply of nurses while graduating enough to meet needs.
7. To solve the problem of nursing care for convalescent and chronic patients either through attendants or in some other manner.

Doctor Faxon declared that it is unwise to recommend that all schools fit into a professional mold and questioned whether hospitals would be willing to finance schools over which they had little or no control.

In the small hospital section a storm of controversy was aroused by a statement by Dr. A. F. Branton, Willmar, Minn., that "if nurses do not do something to provide nursing service needed in rural areas, the hospitals will begin to train attendants." Those who protested declared that sick people in rural communities had just as much need of competent nurses as those in cities.

"The real question," said Alden B. Mills, managing editor, The MODERN HOSPITAL, "is not urban *versus* rural but rather getting the kind of service which is suited to the particular need. Practically every significant study of nursing and medical service has concluded that there was real need for a less well trained person who would combine housekeeping with nursing duties. But such people ought to be carefully regulated as to types of work they will undertake and effectively supervised while on the job. If they are turned loose by hospitals without regulation and supervision, it will make a bad situation much worse."

Miss Pfefferkorn's Studies

Nursing costs, nursing organization and the nursing care given to patients are interdependent, declared Blanche Pfefferkorn, R.N., director of studies, National League of Nursing Education. When the quantity of nursing is reduced below a certain level the quality will fall. Miss Pfefferkorn suggested that the ratio of nurses to patients was not a good measure of nursing service since it took no account of the length of the nursing week which may vary from forty-five to sixty or more hours. A better measure is the average number of hours of bedside nursing in each twenty-four hours, she said.

A recent study of a representative group of general and children's hospitals in which good nursing service is given, showed a wide range of practice. The median figures were as follows: adults, medical or surgical, 3 to 3½ hours of bedside nursing to each patient in each twenty-four hours; obstetrical, mothers or infants, 2½ to 3 hours; pediatric: infants, 6 hours, children two to five years old, 4½ hours and children five years and older, 4 hours.

A reorganization of nursing schools to provide an adequate teaching staff was called for by Sister Mary Redempta, R.S.M., director of nursing education, Central School of Nursing, Detroit. "The day is gone," declared Sister Redempta, "when the student pays the hospital through her service and when the hospital depends upon the students for most of its nursing service. At present nursing faculties are usually a shadowy skeleton of the nursing and medical staffs, adding teaching to other heavy duties. It is unfair to ask doctors to lecture to nurses without pay in the evening — unfair to both the doctors and the students."

It is a mistake to load on a board of nursing examiners the supervision of schools whose graduates they must also examine, said Grace Phelps, R.N., superintendent, Doernbecher Memorial Hospital for Children, Portland, Ore. She urged that state boards revert as soon as possible to their proper function of selecting those who are qualified to nurse. In this connection, Adda Eldridge, Chicago, pointed out that in some states, notably New York and Minnesota, the inspection of schools and the examination of graduates are kept separate.

Standards for Civil Service

Dr. M. H. Worthington, Research Hospital, Chicago, asked for the help of boards of nursing examiners and nurse associations in raising the standards of civil service nurses. Many of them, he stated, are low grade nurses but they have passed state board examinations.

Dr. Malcolm T. MacEachern declared that students should be accepted into nursing schools on the basis of health, mental ability, personality and cultural qualifications. He particularly stressed the necessity of higher health standards for admission.

A warning that the oversupply of nurses may soon give place to an undersupply through the effect of the public health provisions of the Social Security Act was voiced by Robert E. Neff, superintendent, University of Iowa Hospitals, Iowa City. He pointed out that the act should stimulate considerable extension of public health work and thus absorb many nurses now unoccupied. Other speakers on the other hand declared that the schools are still graduating about three times as many nurses as are needed to replace those who leave the profession because of death, marriage or other causes.

Streamline Effects Mark Exhibitors' 1935 Display at St. Louis

By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

THE Hospital Exhibitors' Association this year prepared and served its most appetizing dish —a bewildering assortment of items elaborately garnished to whet the taste of every hospital executive. It was as though each manufacturer, having sworn a solemn vow of renewed faith in the hospital field proceeded to lavish extra thought, care and expense in making his 1935 display outstanding.

The effect was stimulating. To an assemblage comprising men and women whose paths have been fraught with difficulties and discouragements during recent years it brought new hope and revived interest. The very apparent indications of progress made in broadening the scope of hospital work and in introducing modern innovations in its routine were in themselves heartening.

First Impressions

The first impression gained on entering the tremendous St. Louis Auditorium was that it was the biggest show of recent years. A more accurate check of the manufacturers and affiliated organizations present substantiated this feeling. Over two hundred exhibits lined the wide aisles.

Second, even the most cursory inspection made it apparent that here was a more diversified display of products than had been assembled for some time. The growth of modern hospitals, and the necessity for applying sound business principles to their various activities and departments are fast becoming recognized, it appears, which accounts for a wider variety of items being groomed for acceptance by the field.

Third, it was a modern show—modern in respect to the products themselves, their application, as well as the manner in which they were presented. Hardly an exhibit that did not either in its lighting or background staging feature the simple, streamline effect which characterizes modern design.

Gone are the days of the glaring white hospital room. In line with this trend it is only to be expected that equipment and accessories should likewise assume color. It is not so great a shock, therefore, to find a continuous bath finished in a soft shade of peach.

New dress for oxygen therapy equipment! Step up and be introduced. No need for further consternation on the part of the patient when he sees being rolled into the room this formidable looking apparatus. It just isn't that any more. The long cylindrical effect of the tank when encased is particularly good, and offers a happy solution to the problem of hiding from view an unsightly fixture. Even the color is friendly, a cool, fresh green.

Hospital furniture of today isn't what it used to be either. Instead of just one type, a bewildering assortment of styles awaits the buyer — cherry, maple, mahogany, aspen, stump walnut—take your pick. All good looking—every one of them. Again the trend is modern. If there is any doubt of this just glimpse the dresser with its circular mirror.

Even the master electric clock has the face to go modern, but a dignified face at that, almost venerable in silver and black. Surely a pleasant way to watch time slip by.

No longer need the business office lie awake nights thinking up alibis for inaccuracies. It can't possibly go wrong any more with the tabulating equipment now available, designed especially for hospital use. There is a cash register, too, for billing accounts which works wonders and is guaranteed never to cheat anyone. Behind all this modern office equipment is a significant thought. Hospitals are assuming the guise of real business and doing it in a businesslike way.

Giving the Patient a Break

If the patient cannot have his picture taken, or should his modesty restrain him from doing so, a happy surprise to spring on him is a portable x-ray outfit. It does the trick irrespective of the type of fracture apparatus that may be in use. No fear of shocking him, or anyone else for that matter. The machine is absolutely shockproof.

Giving the patient a break after he has had one is the slogan of numerous manufacturers. One in particular has conceived the idea of a useful combination chair and cot which has thirty-five adjustments. The back rest is constructed with metal strips connected to coil springs providing resiliency. There are ten easily adjustable positions from vertical to horizontal, the leg rest has ten adjustments and there are also ten positions for the length of the patient's limbs. Who could ask for more?

Your eyes do not deceive you. That bed is moving slowly back and forth. It is for cardiovascular diseases. Comfortably the patient is raised and lowered, the head and feet alternately, thus emptying and filling the arteries, veins and capillaries at regular intervals, inducing the blood flow to and from the extremities. It takes just three and a half minutes to make each complete swing.

While on the subject of beds to say nothing of mechanical devices a fracture bed is available which can be raised or lowered slowly without the slightest jerk or jar to the patient. Press the button, and away you go. A silent electric motor does the trick. And the construction is such that the bedding can be changed, the mattress removed and turned without discomfort to the patient and with minimum effort.

Plenty of Action

In line with progress in obstetric technique is a bed constructed on a one-piece frame. The entire bed is raised or lowered by a handle in relation to the height of the stretcher as well as the height of the physician. A chromium wheel elevates quickly to the shock position. One other point about this equipment — its newly designed stirrups and foot rest. There are only two handles to each stirrup, controlling its action. The foot rests are swiveled, permitting free motion, a definite advantage.

Suction-pressure apparatus for use in peripheral vascular treatment was very much in evidence. And it may be had in the latest shades.

Growing recognition of the importance of what happens downstairs where the dietitian and her staff hold forth was manifest in the large number of exhibits of kitchen equipment. Everything ranging from the most modern interpretation of the cooking stove to the tiniest cream pitcher for tray service was to be found somewhere.

There can now be little question that china with the narrow rim has come to stay. Its great advantage in affording the same or greater food area, at considerable saving of space on the tray has been demonstrated to the complete satisfaction of many. No longer, either, can hospital china be accused of having about it that drab institutional air. It blossoms forth gaily in numerous decorative patterns guaranteed to add zest to the poorest appetite.

Action was introduced wherever possible, causing the passer-by to stop, look, and even listen to the explanations offered. Invariably too, the visitor departed accurately informed regarding what he had seen. It was that kind of a show.

F. G. Carter, M.D.

MacLean President-Elect of Administrators

Basil C. MacLean, M.D.

SEVENTY-SIX persons were inducted into membership or fellowship in the American College of Hospital Administrators at the second annual convocation held in St. Louis. Dr. B. C. MacLean, Strong Memorial Hospital, Rochester, N. Y., was chosen president-elect of the college and Dr. Fred G. Carter, Ancker Hospital, St. Paul, Minn., was installed as president to succeed Robert E. Neff, University of Iowa Hospitals, Iowa City. It was decided to change the name of the executive officer from "director-general" to "executive secretary." J. Dewey Lutes, Ravenswood Hospital, Chicago, was reelected to the office.

Honorable Paul V. McNutt, governor of Indiana, made the principal address at the convocation. He outlined the proper field of activity of the state in hospital work. The state, he said, should be responsible first for custodial care of persons who cannot hope to be returned to health and who are dangerous to the community or themselves, for example, the mentally ill, the feeble-minded, epileptics and the tuberculous.

A second responsibility is general hospital care for those in small communities who are not able to make local arrangements because they have no hospital facilities. While most of them will be indigent, it was urged that pay cases also be accepted at modest rates.

A third class is composed of those who require such specialized treatment that most hospitals cannot afford the specialized equipment necessary for their care, for example, orthopedic cases. Finally the state has a responsibility to provide care for other types of cases that it needs for teaching purposes.

President Sets Four Tasks

A definite program of work for the college was outlined by Dr. Fred G. Carter in his presidential address. Four tasks set by Doctor Carter for the college were: (1) outlining what constitutes a good administrator; (2) promoting means for the training of hospital administrators; (3) creating a demand for trained and competent administrators on the part of trustees and the public; (4) protection of trained and competent persons in their posts. Doctor Carter's paper will appear in an early issue of The MODERN HOSPITAL.

Doctor Carter also presented the report of the study committee on the qualifications and functions of the hospital administrator. This is the first definite piece of work completed and made public by the college and it was well received by the field.

"In general, the governing board should concern itself with policies and the administrator with practice," declared Dr. Basil C. MacLean, "but many are the variations of such a principle, depending on the structure of organization, the type of control and the strength of personalities. Not infrequently trustees recognized for their ability, judgment and business sense fail to understand that a hospital, while not a business, must be conducted in a businesslike manner.

Burdens of Trusteeship

"Between the trustee who does too little and the trustee suffering from meddler's itch, is the one who is always available for assistance and advice, who is impartial in his attitude and sympathetic in his approach to the problems of the multi-ringed hospital circus. On his shoulders are laid the burdens of trusteeship of the hospitals of the country. He is interested in knowing whether the hospital is playing fair with the public, the profession and its own personnel. He wants to know whether nurses should be educated to be pseudo-university professors or trained to be real nurses, whether staff appointments should be made on merit or based on bulk of private practice and whether hospital care should become a pawn of politicians."

In discussing "The Administrator and the Community," Dr. Arthur C. Bachmeyer, University of Chicago Clinics, declared that "the administrator should take advantage of every opportunity to work with both public and private health and welfare agencies in his community, endeavor to understand their viewpoint and their purpose and be cooperative and willing to join in discussions and the formulation of plans and programs to meet the community's needs. Where hospital councils or councils of social agencies exist, it is his responsibility to participate in their activities."

"There are, or should be, no trade secrets in hospital administration," declared Dr. G. Harvey Agnew, secretary, department of hospital service, Canadian Medical Association, Toronto. "No administrator, no matter how successful, but owes the major part of his success to the ideas and efforts of others. Cordial relationships require the personal touch. Administrators, trustees and nursing directors should be personally known to each other. Above all there must be sympathy, based on understanding, and to achieve this there must be frankness. Problems should be approached from the community viewpoint. This is difficult and necessitates studying the actual needs of the community. The tendency is to duplicate what the other fellow has rather than to fulfill the greater public service of filling the gaps."

A complete roster of the members and fellows of the college including these admitted at the St. Louis convocation follows.

Honorary Fellows

Dr. G. Harvey Agnew, Canadian Medical Association, Toronto; Dr. Otho F. Ball, The MODERN HOSPITAL Publishing Company; Richard P. Borden, Union Hospital, Fall River, Mass.; Dr. Bert W. Caldwell, American Hospital Association; Dr. E. H. L. Corwin, United Hospital Fund; Margaret M. Cummings, New York; William J. Ellis, Commissioner of Hospitals of the State of New Jersey; Sister John Gabriel, provincial administrator, Mount St. Vincent, Seattle; Rt. Rev. Mgr. Maurice F. Griffin, trustee, American Hospital Association, Cleveland; Dr. Thomas Howell, Society of the New York Hospital, New York; Dr. Malcolm T. MacEachern, American College of Surgeons; Dr. John M. Peters, Providence, R. I.; Dr. Christopher G. Parnall, Rochester General Hospital, Rochester, N. Y.; C. S. Pitcher, Philadelphia; Rev. Alphonse T. Schwitalla, St. Louis University School of Medicine, St. Louis; Daniel T. Test, Towson, Md.; Dr. W. H. Walsh, Chicago; Dr. Michael M. Davis, Julius Rosenwald Fund, Chicago; Emma Lucas Louie, Jennie Edmundson Memorial Hospital, Council Bluffs, Iowa.

Fellows and Members

Arkansas—Lee C. Gammill,* Baptist State Hospital, Little Rock.

California—Dr. B. W. Black, Alameda County Institutions, Oakland; Dr. William R. Dorr,* Riverside County Hospital, Arlington; Ritz E. Heerman,* California Hospital, Los Angeles; Andrew C. Jensen,* Fairmont Hospital, San Leandro; E. L. Slack, Samuel Merritt Hospital, Oakland; Dr. Leon M. Wilbor, San Francisco Hospital, San Francisco; George U. Wood,* Peralta Hospital, Oakland.

*Indicates "member."

Colorado—Walter G. Christie,* Presbyterian Hospital, Denver; Guy Hanner, Beth-El General Hospital, Colorado Springs; Dr. Maurice H. Rees, Colorado General Hospital, Denver; Frank J. Walter, St. Luke's Hospital, Denver; Robert B. Witham, Children's Hospital Association, Denver.

Connecticut—Oliver H. Bartine, Bridgeport Hospital, Bridgeport; Dr. Allan Craig, Charlotte Hungerford Hospital, Torrington; Sidney Davidson, Grace Hospital, New Haven; Joseph W. Hinsley,* Hartford Hospital, Hartford; Anna M. Griffin,* Danbury Hospital, Danbury; M. Ellen McIntyre,* Meriden Hospital, Meriden; Fred J. Loase,* Greenwich Hospital, Greenwich; George F. Sauer, Stamford Hospital, Stamford; Dr. Lewis A. Sexton, Hartford Hospital, Hartford; Frances P. West,* Middlesex Hospital, Middletown.

Florida—John A. Bowman,* Munroe Memorial Hospital, Ocala; Dr. W. L. Shackelford,* Good Samaritan Hospital, West Palm Beach; F. M. Walker, Duval County Hospital, Jacksonville.

Georgia—W. D. Barker, Georgia Baptist Hospital, Atlanta; George R. Burt,* Piedmont Hospital, Atlanta; Jessie M. Candlish, Henrietta Egleston Hospital for Children, Atlanta; J. B. Franklin, Grady Hospital, Atlanta; Dr. Russel H. Oppenheimer, Emory University Hospital, Emory University; Dr. John H. Snoke,* University Hospital, Augusta.

Illinois—Dr. A. C. Bachmeyer, University of Chicago Clinics; Asa S. Bacon, Presbyterian Hospital, Chicago; Mabel Binner, Children's Memorial Hospital, Chicago; John Dinsmore, Chicago; Maurice Dubin, Mount Sinai Hospital, Chicago; E. I. Erickson, Augustana Hospital, Chicago; Paul Fesler, Wesley Memorial Hospital, Chicago; E. E. Hanson, Lutheran Deaconess Hospital, Chicago; L. C. von der Heidt, West Suburban Hospital, Oak Park; Howard E. Hodge, Chicago; Anna M. Holtman,* Christian Welfare Hospital, East St. Louis; Agnes Hatch,* DeKalb Public Hospital, DeKalb; Ralph Hueston,* Silver Cross Hospital, Joliet; C. T. Johnston, Washington Boulevard Hospital, Chicago; J. Dewey Lutes, Ravenswood Hospital, Chicago; Edna H. Nelson,* Women and Children's Hospital, Chicago; Ada Belle McCleery, Evanston Hospital, Evanston; Omer B. Maphis,* Bethany Hospital, Chicago; Charles A. Lindquist,* Sherman Hospital, Elgin; A. E. Paul,* Englewood Hospital, Chicago; Dr. Herman Smith, Michael Reese Hospital, Chicago; E. R. Snyder,* Wesley Memorial Hospital, Chicago; Dan Traner,* Swedish American Hospital, Rockford; Charles Wordell, St. Luke's Hospital, Chicago.

Indiana—Rev. John G. Benson, Methodist Episcopal Hospital, Indianapolis; A. G. Hahn, Protestant Deaconess Hospital, Evansville.

Iowa—Sister Mary Alberta,* Mercy Hospital, Council Bluffs; Robert E. Neff, University of Iowa Hospital, Iowa City; Robert A. Nettleton, Iowa Methodist Hospital, Des Moines; Erwin C. Pohlman,* University of Iowa Hospital, Iowa City; Clinton F. Smith, University of Iowa Hospital, Iowa City; Dr. Charles H. Sprague,* Broadlawns, Polk County Public Hospital, Des Moines.

Kentucky—Adeline M. Hughes,* Jewish Hospital, Louisville; Lake Johnson, Good Samaritan Hospital, Lexington; Dr. E. T. Thompson,* formerly at John N. Norton Memorial Infirmary, Louisville.

Massachusetts—Miriam Curtis, Cooley-Dickinson Hospital, Northampton; Dr. Charles H. Pelton,* Boston City Hospital, Boston; Scott Whitcher, St. Luke's Hospital, Inc., Bedford; Dr. W. Franklin Wood, McLean Hospital, Waverley.

Michigan—Amy Beers, Hackley Hospital, Muskegon; Sister Marie Bernard,* St. Joseph's Mercy Hospital, Detroit; Charles E. Findlay,* Butterworth Hospital, Grand Rapids; Dr. Harley A. Haynes, University Hospital, Ann Arbor; Sister M. Carmelita Manning, formerly at St. Joseph's Mercy Hospital, Pontiac; Dr. Donald M. Morrill, Blodgett Memorial Hospital, Grand Rapids; Sister M. Ligouri Thibodeau,* Mercy Hospital, Cadillac; Sister Mary Reginald,* Mount Mercy College and Academy, Grand Rapids.

Minnesota—Ray Amberg,* University of Minnesota Hospital, Minneapolis; Victor Anderson, Abbott Hospital, Minneapolis; Sister Anna Bergeland,* Deaconess Hospital, Minneapolis; A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul; Dr. Fred Carter, Ancker Hospital, St. Paul; James J. Drummond, Worrall Hospital, Rochester; Elizabeth McGregor, Gillette State Hospital for Crippled Children, St. Paul; Harry J. Harwick, Kahler Hospital, Rochester; Harriet S. Hartry, formerly at St. Barnabas Hospital, Minneapolis; John Harvey Mitchell, Colonial Hospital, Rochester; James McNee, St. Luke's Hospital, Duluth; Joseph G. Norby, Fairview Hospital, Minneapolis; Sister Mary Patricia, St. Mary's Hospital, Duluth; Magdalena M. Rau,* St. John's Hospital, St. Paul; Dr. Charles E. Remy, Minneapolis General Hospital, Minneapolis; Alfred G. Stassel, Eitel Hospital, Minneapolis; Dr. Peter Ward, Chas. T. Miller Hospital, Inc., St. Paul; Roy Watson, Kahler Hospital, Rochester.

Missouri—E. Muriel Anscombe, Jewish Hospital, St. Louis; L. C. Austin, Menorah Hospital, Kansas City; Dr. Walter J. Grolton, St. Louis City Hospital, St. Louis; E. E. King, Missouri Baptist Hospital, St. Louis.

New Hampshire—Mary L. Whittaker, Margaret Pillsbury General Hospital, Concord.

New Jersey—Florence P. Burns,* Babies Hospital, Colt-Memorial, Newark; Mary Stone Conklin, Hackensack Hospital, Hackensack; Eleanor E. Hamilton,* Presbyterian Hospital, Newark; Dr. George O'Hanlon, Jersey City Medical Center, Jersey City; Edgar C. Hayhow, Paterson General Hospital, Paterson; F. Stanley Howe,* Orange Memorial Hospital, Orange; Rev. Thomas A. Hyde, Christ Hospital, Jersey City; Nellie McGurnan,* Atlantic City Hospital, Atlantic City; Dr. Paul D. Keller, Bankers Indemnity Insurance Company, Newark; Daisy C. Kingston, Somerset Hospital, Somerville; Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark.

New York—Dr. E. M. Bluestone, Montefiore Hospital, New York; Sister M. Suitbertha,* Mary Immaculate Hospital, Jamaica; Dr. J. G. Copeland, Albany Hospital, Albany; Dr. M. L. Dryfus,* Beth Moses Hospital, Brooklyn; Jane Durham,* Nurses' Central Club, New York; Sister M. Eugenia, St. Catherine's Hospital, Brooklyn; Boris Fingerhood, Israel-Zion Hospital, Brooklyn; Louis J. Frank, Beth Israel Hospital, New York; Dr. Emanuel Giddings, Morrisania Hospital, New York; George E. Halpern, Lebanon Hospital, New York; Harold A. Grimm,* Millard Fillmore Hospital, Buffalo; Dr. Basil C. MacLean, Strong Memorial Hospital, Rochester; Ernest G. McKay, Arnot Ogden Memorial Hospital, Elmira; Dr. C. W. Munger, Grasslands Hospital, Valhalla; Mary C. Murphy,* Rome Hospital and Murphy Memorial Hospital, Rome; T. T. Murray, Memorial Hospital, Albany; James U. Norris, Woman's Hospital, New York; Jerome F. Peck, Binghamton City Hospital, Binghamton; Mary G. McPherson, Ellis Hospital, Schenectady; George Rebush,* West Side Hospital and Dispensary, New York; Austin J. Shoneke, New Rochelle Hospital, New Rochelle; M. Marion Smith,* New York Infirmary for Women and Children, New York; Carl P. Wright, Department of Hospitals, New York.

North Carolina—Newton Fisher,* James Walker Memorial Hospital, Wilmington.

Ohio—Dr. Robert H. Bishop, Jr., University Hospitals, Cleveland; Hulda C. A. Fleer,* Aultman Hospital, Canton; A. E. Hardgrove, City Hospital, Akron; Frank W. Hoover,* Elyria Memorial Hospital, Elyria; Worth L. Howard,* University Hospitals, Cleveland; Dr. Walter E. List, Jewish Hospital, Cincinnati; John R. Mannix, University Hospitals, Cleveland; Margarit M. Reilly,* Starling-Loving University Hospital, Columbus; Mary A. Rostance,* Warren City Hospital, Warren; Dr. Merrill F. Steele, Grant Hospital, Columbus; Byron W. Stewart, Youngstown Hospital, Youngstown; Rev. Philip Vollmer, Jr., Fairview Park Hospital, Cleveland; George Wilson, Toledo Hospital, Toledo; Dr. C. S. Woods, St. Luke's Hospital, Cleveland; Mary E. Yager, Women's and Children's Hospital, Toledo.

Oregon—Carolyn E. Davis, Good Samaritan Hospital, Portland.

Pennsylvania—Malcolm R. Baxter,* Rochester General Hospital, Rochester; Mabel Barr, St. Christopher's Hospital for Children, Philadelphia; Howard E. Bishop, Robert Packer Hospital, Sayre; W. M. Breitinger, Reading Hospital, Reading; M. H. Eichenlaub, Western Pennsylvania Hospital, Pittsburgh; Edith B. Irwin, Westmoreland Hospital, Greensburg; Alford R. Hazzard,* Easton Hospital, Easton; Lillian A. Hollohan,* Indiana Hospital, Indiana; Jeannette L. Jones, South Side Hospital, Pittsburgh; Dr. Henry I. Klopp, Allentown State Hospital, Allentown; Dr. Mary R. Lewis, Woman's Hospital, Philadelphia; Anna Lauman, Philipsburg State Hospital, Philipsburg; Elmer E. Matthews, Wilkes-Barre General Hospital, Wilkes-Barre; Herman S. Mehring,* Pennsylvania Hospital, Philadelphia; May A. Middleton, Methodist Episcopal Hospital, Philadelphia; Mary B. Miller,* Presbyterian Hospital, Pittsburgh; Dr. Henry K. Mohler, Jefferson Medical College Hospital, Philadelphia; Harold T. Prentzel,* Friends Hospital, Frankford, Philadelphia; Nicholas J. Sepp,* Homeopathic Medical and Surgical Hospital, Pittsburgh; Dr. E. E. Shifferstine, formerly at Coaldale State Hospital, Coaldale; Dr. Donald C. Smelzer, Graduate Hospital of the University of Pennsylvania, Philadelphia; John M. Smith, Hahnemann Hospital, Philadelphia; Mary V. Stephenson, Hospital of the University of Pennsylvania, Philadelphia; Melvin L. Sutley, Delaware County Hospital, Drexel Hill; Esther J. Tinsley, Pittston Hospital, Pittston; Sister M. Thomasine, St. Francis Hospital, Pittsburgh; Jessie J. Turnbull, Elizabeth Steel Magee Hospital, Pittsburgh; Stephen Wierzbicki,* Wills Hospital, Philadelphia.

Rhode Island—Carl A. Lindblad, Homeopathic Hospital of Rhode Island, Providence.

South Carolina—F. O. Bates, Roper Hospital, Charleston; Charles H. Dabbs,* Tuomey Hospital, Sumter.

Tennessee—Dr. Henry Hedden, Methodist Hospital, Memphis; George D. Sheats, Baptist Memorial Hospital, Memphis; Dr. Eugene B. Elder, Knoxville General Hospital, Knoxville.

Texas—E. M. Collier, West Texas Baptist Sanitarium, Abilene; Ara Davis,* Scott and White Hospital, Temple; Florence Gants,* Texarkana Hospital, Texarkana; Robert Jolly, Memorial Hospital, Houston; Martha P. Roberson, Medical & Surgical Hospital, San Antonio; Josie M. Roberts,* Methodist Hospital, Houston; Margaret H. Rose,* Wichita General Hospital, Wichita Falls; May Forster Smith,* Bradford Memorial Hospital for Babies, Dallas; Bryce L. Twitty, Baylor University Hospital, Dallas; Eva M. Wallace,* Wichita Falls Clinic Hospital, Wichita Falls; Dr. Lucius R. Wilson, John Sealy Hospital, Galveston.

Virginia—Dr. Lewis E. Jarrett,* Hospital Division, Medical College of Virginia, Richmond; Dr. Knowlton T. Redfield, Norfolk Protestant Hospital, Norfolk.

Washington—Dr. Burton A. Brown, Pierce County Hospital, Tacoma; J. V. Buck,* St. Luke's Hospital, Spokane; C. J. Cummings, Tacoma General Hospital, Tacoma; Cecile T. Spry, General Hospital, Everett; Joseph R. Schneider,* Aberdeen General Hospital, Aberdeen.

Wisconsin—Dr. Robin C. Buerki, State of Wisconsin General Hospital, Madison; Grace T. Crafts,* Madison General Hospital, Madison; Carolyn M. Fenby,* Methodist Hospital, Madison; Rev. Herman L. Fritschel, Milwaukee Hospital, Milwaukee.

Canada—C. J. Decker, Toronto General Hospital, Toronto, Ont.; Dr. A. K. Haywood, Vancouver General Hospital, Vancouver, B. C.; Dr. S. R. D. Hewitt, St. John General Hospital, St. John, N. B.; Edith M. McKee, Brantford General Hospital, Brantford, Ont.; Dr. John C. Mackenzie,* Montreal General Hospital, Montreal, Que.; A. J. MacMaster, Moncton Hospital, Moncton, N. B.; Stanley T. Martin,* Ingram & Bell, Toronto, Ont.; Rev. Mother M. Patricia,* St. Joseph's Hospital, London, Ont.; Georgie L. Rowan, Grace Hospital Division of the Toronto Western Hospital, Toronto, Ont.; Henry A. Rowland, Riverdale Isolation Hospital, Toronto, Ont.; Dr. George F. Stephens, Winnipeg General Hospital, Winnipeg, Man.; A. J. Swanson, Toronto Western Hospital, Toronto, Ont.

Church Support for Church Hospitals Asked at Protestant Meeting

E. E. King

A. M. Calvin

WITH a program that centered almost entirely upon the work of church hospitals and their relations to church bodies, the American Protestant Hospital Association apparently found the formula for renewed life. The attendance at meetings this year was four or five times as large as last year and the interest seemed to be high.

A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul, Minn., was chosen president-elect of the association and E. E. King, Missouri Baptist Hospital, St. Louis, was installed as president. The association decided to extend its program next year by including a religious session on Sunday afternoon, being assured by the American College of Hospital Administrators that that period would be left free for such a purpose.

Declaring that the hospital field will soon need to make new capital expenditures to replace antiquated buildings or extend hospital service, Dr. C. S. Woods, St. Luke's Hospital, Cleveland, declared that the public would respond to such appeals if they were made on a sound basis. He vigorously scored those hospitals that keep going by running up large accounts with vendors. "Hospitals are not serving their communities fairly and honestly if they do not insist on getting money for the work they do," he declared. Every patient able to pay should pay, Doctor Woods declared.

Sources for Funds Named

He recommended additional sources of funds as follows: (1) installment payment plans through a legal nonprofit small loan corporation which is interested in the patient and the hospital; (2) group hospitalization; (3) state payments for auto accident cases as under the Ohio law, and (4) payment from tax funds for other indigent cases.

In discussing Doctor Wood's paper, Asa Bacon, Presbyterian Hospital, Chicago, took issue with his demand for tax aid for the care of the indigent. "I think we shall get further without state aid than with it," said Mr. Bacon. "But we shall have to work hard to get support from other sources." He pointed out that in 1929 only 1.9 per cent of the income reported under federal income tax laws was deducted as gifts to charitable organizations although at that time corporations and individuals were permitted to deduct 15 per cent for such gifts. This indicates that there is still a large field for increased contributions, Mr. Bacon declared.

Church hospitals will last as long as churches themselves, declared Carolyn E. Davis, superintendent, Good Samaritan Hospital, Portland, Ore. But if the church hospital is to continue it must learn to give real coopperation to the other hospitals in the same community, avoiding needless duplication of effort, she said.

"Christian people are not interested in keeping institutions alive merely for sentiment or because of denominational prestige," said A. M. Calvin. "They know that there are too many good causes which need their support. On the other hand, I am sure they are of the opinion that too great sacrifice cannot be made to maintain church hospitals that really prove a blessing to mankind."

The church hospital should be subservient to the church and the church should give the hospital parentage and support, according to J. G. Norby, superintendent, Fairview Hospital, Minneapolis. Church hospitals must be conducted as a church service with Christian nurses, doctors and administrative staff and with service to patients equal to the best of other institutions, he said.

Rev. John G. Benson, Methodist Hospital, Indianapolis, urged that the church hospitals should not apologize for their church affiliation and should give their charitable service to those in their church group. He also urged that hospitals be humanized and that a technique be developed for philanthropy that will fit all purses. He said that church hospitals should root out narrow denominationalism.

A round table conducted by Albert G. Hahn, Protestant Deaconess Hospital, Evansville, Ind., discussed the spiritual accomplishments of hospitals during the past year. These included choir singing on Sunday, vespers services, support of foreign missions, visits by hospital ministers, Y. W. C. A.'s, volunteer bands and various types of Christmas exercises.

In his presidential address Rev. C. C. Jarrell, Methodist Episcopal Church South, Atlanta, Ga., discussed national issues and problems. "Is there," he asked, "a middle ground between regimentation and laissez faire? I think there is and that it resembles the voluntary hospital. In my opinion the voluntary hospital will doubtless adapt itself to a changing social order but it will continue to be voluntary."

Church Hospital Has Four Aims

Some church hospitals are liabilities to Christianity, stated Robert Jolly, Houston Memorial Hospital, Houston, Texas, and president, American Hospital Association. "To be assets to the church, these hospitals should be living forces expressing Christianity and gaining adherents to the church. The first consideration of a church hospital is healing, the second is active evangelism, the third, Christian education and the fourth, benevolence, which must not be extended so far that hospitals cannot pay bills."

Mr. Jolly pointed out that church support to hospitals has been meager.

Robert E. Neff, president, American College of Hospital Administrators, outlined the work and future plans of the college.

At the business session on Monday morning it was reported that the association would close the year with about $1,000 surplus from operations and $500 in permanent funds.

Dr. Fred C. Zapffe, secretary-treasurer, Association of American Medical Colleges, Chicago, outlined the work of that association in compiling information about medical students that would be helpful to hospitals in choosing interns.

PLANT OPERATION • • • •

Conducted by John R. Mannix and R. C. Buerki, M.D.

Day by Day in the Hospital Pharmacy

By I. Rogin, Ph.G.
Chief Pharmacist, Mount Sinai Hospital, New York City

THE hospital drug room is an important branch of the hospital organization and should be centrally located so as to be within easy reach of every department. If the hospital has an out-patient department, the pharmacy should be between that department and the hospital proper. It is unfortunate that in many hospitals the drug rooms are relegated to obscure corners, not infrequently basements, with insufficient light and ventilation.

The drug room at the Mount Sinai Hospital, New York City, is ideally located in an area between the hospital and the out-patient buildings. It is a two-story building. The upper floor consists of a large, light and well ventilated dispensing room and an office for the chief pharmacist. It is equipped with built-in metal fixtures, an abundance of metal drawers and closets, marble tables, a large electric refrigerator and an electric elevator.

In the basement are a large workroom, two small and two large storerooms and an outside vault for inflammable drugs. The workroom is equipped with soapstone tables, steam kettles, monel metal percolators, suppository machines, a power ointment mixer and a water still. All this equipment has been found necessary for efficient work and for local preparations of standard pharmaceuticals.

The working staff consists of six pharmacists and two porters. A staff of this size is essential to handle the hospital work and the large out-patient clinics. Each man has his work definitely assigned and is held responsible for carrying it on efficiently. During the busy dispensary hours all the pharmacists work together to handle the out-patient prescriptions.

The work in the drug room begins at 7:30 a.m. for the porters and at 8:30 a.m. for the pharmacists. It consists mostly of refills and some new orders. Approximately 450 orders are handled between the hours of 8:30 and 10:00 a.m. The empty drug containers are delivered to the drug room in baskets and are taken out and assorted on the tables by the porters in such a way that each druggist finds the work assigned to him in front of him. All labels are examined during this time and old labels are replaced. If there is no printed label for a certain drug, we print the label instead of writing it.

Lower manufacturing room for preparation of bulk pharmaceuticals and bottling of standard prescriptions.

Each ward and floor (there are more than thirty) has two order books — one for refills, the other for new orders. The regular order book is used by the charge nurses to keep a record of the orders sent to the drug room and to check the drugs when they are returned to the wards. The special order book is used only for new orders, which must be approved by the supervisors of the respective pavilions. There is a separate book for narcotic orders which must be signed by the doctor in charge. No verbal or telephone orders are accepted.

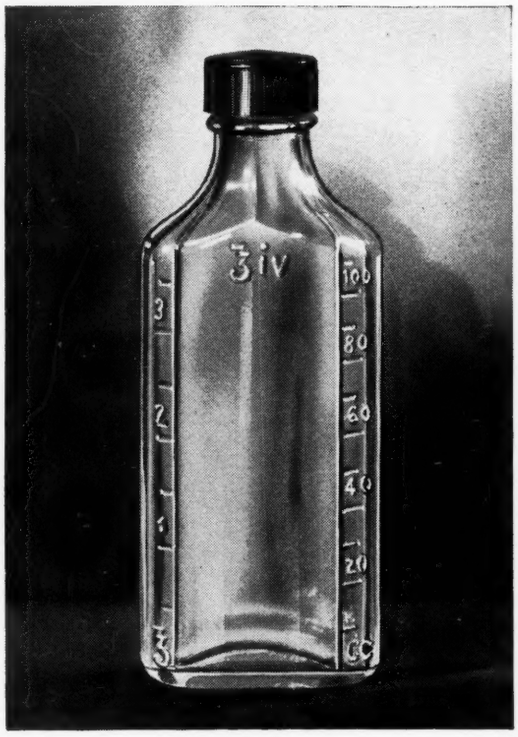
The doctors are instructed to write their prescriptions instead of giving verbal orders to the nurses. To place responsibility, all orders are signed by the druggists after they are filled. These precautions are necessary to reduce to a minimum the possibility of errors.

Ways to Cut Cost

Economy is our daily watchword. This does not lower the standard or the medicinal value of the drugs. Whenever practicable, solutions are used instead of tablets or ampoules. Hypodermic tablets are expensive and take considerable time to dissolve, while the drug in solution form costs considerably less. The saving in some instances is approximately 50 per cent. Hypodermic solutions eliminate a large number of ampoules which are purchased for hypodermic use and are very costly. We are making hypodermic solutions of atropine sulphate, caffeine and sodium benzoate, camphor in ether, camphor in oil, codeine phosphate, emetine hydrochloride, hyoscine hydrobromide, morphine sulphate, pilocarpine hydrochloride, sodium cacodylate and strychnine sulphate.

These solutions are dispensed in half-ounce glass stoppered bottles, flint or amber, according to the nature of the medication. A bottle with a rubber cap can be used if preferred. Most of the hypodermic solutions keep well without a preservative. To some of the solutions it is well to add a grain of chlorbutanol to the ounce. It is a harmless preservative in such small quantities and keeps the solution in perfect condition for a long time. The hypodermic solution is satisfactory because it supplies the nurse with an accurate solution ready for use in any emergency.

The prescription work for the out-patient department constitutes the major part of the drug room work. In 1934, 143,778 prescriptions were compounded in 303 dispensary days, averaging 475 prescriptions a day. To handle this enormous demand a large stock of ready medication is



OWENS

ILLINOIS

& WARE

IMPORTANT TO HOSPITAL SUCCESS

● The prescription you give the patient leaving the hospital is often the only tangible representation of your institution that is taken into the home. It represents there for days or weeks the character of your hospital service.

If your prescriptions are packaged in the crisp, clean-cut, ethical-appearing containers made by Owens-Illinois they will register an impression of excellent condition and careful administration. They will build prestige for your hospital with both patient and doctor.

A liquid prescription put up in either an Owens or Illinois bottle, for example, cannot fail to command the patient's respect by the pleasing design, the clear, sparkling glass, the convenience of the neat molded cap and the security with which this perfectly fitting cap protects against spillage and contamination.

Owens-Illinois quality prescription ware—including the famous Emerald Green ointment jars, powder jars, dropper bottles and capsule and tablet containers—are produced with the same kind of care and skill that maintains in your laboratory. Accuracy of contents, strength and meticulous inspection prevent losses from breakage and leakage. Consequently these containers will prove to be of lowest net cost of any obtainable. All come to you electrically sterilized, capped, and ready for use. Your inquiry is invited.
Owens-Illinois Glass Company, Toledo, O.

OWENS-ILLINOIS

Complete Packaging Service

LOOK AT THE BOTTOM OF EVERY BOTTLE • MAKE SURE THE Onlzed TRADE MARK IS THERE

Onlzed

Upper dispensing room showing prescription compounding tables and label desk.

needed. Every pharmacist in the drug room shares in the work of filling stock and placing it in special trays ready for use during the busy hours of the out-patient clinics.

Handling of out-patients during rush hours and eliminating every possible delay constitutes a problem for the pharmacist. In some institutions each patient is handled individually by taking the prescription from one patient, compounding it and then taking care of the next patient in the same manner. It often requires more than one pharmacist and two dispensing windows to handle a small number of patients by this method. It could be adopted successfully only in hospitals with small out-patient clinics. We have to adopt a different method in our busy clinics.

To begin with, our prescription blanks are printed in two colors, white for internal medication, pink for external medication. They consist of three parts, the stub, which is given to the patient, the prescription proper and the label. Before approaching the drug room window the patient has the prescription stamped by the registrar, who also collects the money from the patient. An orderly brings in all the stamped prescriptions, often as many as twenty-five, which are spread on the table and compounded at the same time.

The ready prescriptions are taken over to the window by one of the pharmacists who dispenses them by calling out the numbers in rotation. While the prescriptions are being dispensed, another pharmacist is busy taking care of the next batch of prescriptions. By this method, two druggists can easily compound and dispense 120 prescriptions in one hour, a rate of two prescriptions a minute. The work naturally has to be done fast, and to avoid errors the prescriptions are checked while the labels are being pasted on. We have a uniform scale of prices—fifteen cents for each prescription, no matter what it is. This eliminates the necessity of the pharmacist making charges and collecting money.

Big institutions with large out-patient clinics will naturally consume large quantities of USP drugs and special formula preparations. It would be costly to purchase all these drugs, especially the alcoholic preparations on account of the high tax on alcohol. With a large staff on hand, time could always be found for manufacturing without interfering in any way with the routine work. With the exception of pills and tablets, practically all our pharmaceuticals are made on the premises. It takes each man approximately one-and-a-half hours to take care of his preparations.

A Few Points on Purchasing

Considerable saving can be effected by careful purchasing of drugs for the hospital. A few good contracts for drugs that are being used in large quantities, taking advantage of sales and advance buying when higher prices are anticipated, have given us good results. In hospitals with large clinics much can be saved by buying bottles, tin and paper boxes in odd lots below current market prices. We have frequently saved by purchasing a few hundred gross of bottles with some name stamped on them for about 50 per cent of the market price. While a bottle of this kind may not be satisfactory to the retail pharmacist, it will serve its purpose for the clinics.

To buy successfully and to be able to take good care of the stock on hand, records are indispensable. We have adopted for this purpose a card system, arranged alphabetically, with the date of purchase, name of vendor, quantity purchased and price paid. Whenever a drug has to be ordered,

G-2-C-1
50M-3-34

THE MOUNT SINAI HOSPITAL
NEW YORK
OUT-PATIENT DEPARTMENT
Retain check until you receive medicine.

THE MOUNT SINAI HOSPITAL
NEW YORK
OUT-PATIENT DEPARTMENT
Patient's No._____ Clinic_____

℞

Signed_____ M. D.

THE MOUNT SINAI HOSPITAL
100th Street and Madison Avenue
NEW YORK
OUT-PATIENT DEPARTMENT
FOR EXTERNAL USE
Apply to_____ times a day
Mix with_____
Drops_____
No._____

G-2-C-1
50M 12-34

THE MOUNT SINAI HOSPITAL
NEW YORK
OUT-PATIENT DEPARTMENT
Retain check until you receive medicine.

THE MOUNT SINAI HOSPITAL
NEW YORK
OUT-PATIENT DEPARTMENT
Patient's No._____ Clinic_____

℞

No. of Doses_____

Signed_____ M. D.

THE MOUNT SINAI HOSPITAL
100th Street and Madison Avenue
NEW YORK
OUT-PATIENT DEPARTMENT

____ *Teaspoonful*	
____ *Tablespoonful*	*every____ hour.*
____ *Powder*	
____ *Pill*	*____ times a day.*
____ *Drop*	

No._____

YOU CAN'T AFFORD TO TAKE CHANCES WITH SENSITIVE SKINS

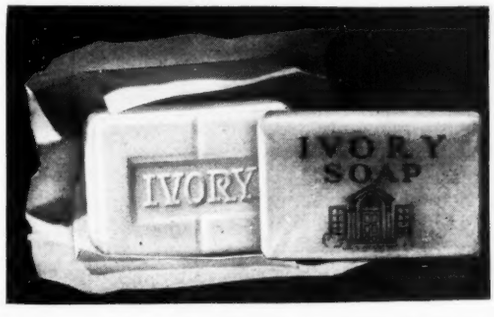
There's no room for guesswork in the modern hospital—in personnel, in equipment, in drugs—or in soap. In each you have a right to expect uniformity of service and dependability.

Ivory Soap gives you the type of dependable service that hospital routine rightly demands.

Ivory is pure—and its purity never varies. Ivory is gentle in its cleansing action. It contains nothing to irritate a sensitive skin—no free alkali, no free fatty acids, no dyes or coloring, no cheap rancid oils.

And Ivory treats hospital budgets with consideration. In fact, Ivory costs little if any more than soaps of doubtful quality and still more doubtful results.

PROCTER & GAMBLE, *Cincinnati, Ohio*



Miniature Ivory

Six miniature sizes of Ivory Soap, in addition to the familiar six and ten-ounce household cakes, are available for hospital use. You may choose from ½ oz., ¾ oz., 1 oz., 1¼ oz., 2 oz., or 3 oz. cakes—wrapped or unwrapped.

we consult the card to learn how fast the drug was used, the price paid for it and the name of the vendor.

In many instances, when a higher price is being quoted for a drug, a simple reminder that a certain quantity of the drug was purchased at a lower price on a certain date, will give you the advantage of the previous lower price. The card system often helps us to get better prices by informing the vendor of the quantities of our yearly purchases which we can find out at a moment's notice. It also helps to eliminate overstocking in case an article, recently purchased, has been mislaid.

Periodical inspection of medicine closets on the wards and private and semiprivate pavilions is essential to avoid unnecessary accumulation of drugs.

As head pharmacist, I not only supervise the drug department but in addition check all the morning orders, make personally a number of stains and reagents for the laboratories, all the hypodermic stock solutions, suppository masses, and about a hundred prescriptions every morning. As you can see, the duties are complicated and carry with them great responsibilities. To manage a hospital pharmacy successfully, the interested and sympathetic cooperation of the hospital management, the supervisors and the drug department staff is necessary. I have been very fortunate in this respect.

Sound Absorption, Insulation and Air Control: An Important Trio

By Edward F. Stevens
Stevens, Curtin & Mason, Architects, Boston

SOUND absorption, insulation and air conditioning are so vitally linked that they should be discussed together. However well planned a hospital may be the efficiency of the plans may be nullified if the patient is disturbed by unnecessary noise without and within, or if he suffers the discomfort of uncontrolled heat in summer and lack of humidity in winter.

Sound absorption should be considered in selecting the hospital site and no site should be selected with noisy surroundings.

The most annoying sounds come from within the building, such as moving of equipment, emptying and washing of utensils, rattling of dishes, clicking of hardware, shuffling of feet, noise from lifts, telephones and other equipment. The use of silent light signals for doctors' and nurses' calls, silent hardware, noiseless electric switches and door closers, rubber covered utensil racks and resilient furniture covers prevent much noise at its source.

To prevent sound from traveling from room to room through partitions and floors, cushioned or spring connections to the construction and partitions filled with sound absorbent material can be used.

It has been found, except in extreme cases, that by the use of sound absorbent material on ceilings of corridors, utility rooms and entrances, a sufficient amount of correction is obtained to make the main hospital much more livable. In special departments, such as delivery rooms, nurseries, dishwashing rooms and rooms with moving machinery, an additional amount of correction is needed. This is obtained in various ways, the simplest being the placing of fibrous or absorbent plaster or precast or molded absorbent tile on the ceilings, having an absorbent coefficient of .50 to .80.

For sections where architectural detail is desired, absorbent terra cotta or artificial stone may be employed. Any material with interconnecting cells presenting a fairly smooth surface may be used.

Sound absorption should not be carried too far, however, for a room with too great absorption coefficient may be as depressing as one with a high degree of noise.

To maintain a proper temperature and humidity in hospitals in all seasons we must have well built structures. If buildings could be of a material impervious to air, without windows and doors, the variation of heat and cold from outside would have little effect on the inside, so that the nearer we can approach this condition the more easily we can maintain any desired temperature and humidity.

We cannot build hospitals without windows and doors, however, so we must make the necessary openings as nearly air-tight as possible. For windows, we may use well built frames fitted with multiple glazed sash, formed by three or four sheets of glass, with ⅛-inch space (3 mm.) between, filled with hydrogen gas and permanently sealed at the edges. An addition of 2 inches (50 mm.) of good insulation on the walls and room is sufficient in most climates, so in applying insulations to walls and windows we effect soundproofing and insulation at one stroke.

We have touched on the comfort afforded the patient by sound absorption of unpleasant noise and by insulation against extremes in weather. Now let us consider air conditioning.

For Comfort and Health

American physicians are in general agreement as to what constitutes comfort conditions most conducive to good health. They have found that an effective temperature of from 68° to 71° F. (20° to 22° C.) is most desirable. The effective temperature is the actual temperature of the air coming into contact with the body and is generally one or two degrees below the wet bulb temperature.

In producing comfort conditions within an enclosure, it is necessary that the use of windows for ventilation be abandoned. This is necessary in order to maintain the proper balance and reduce the cost of operating the system. This means that we have resorted to and depend entirely upon mechanical means for all air movements. In producing these comfort conditions, we have found it necessary to perform simultaneously the following functions during the cooling cycle:

1. Remove the excess moisture or humidity from the air.
2. Remove the excess heat from the air.
3. Supply a minimum of one pound of fresh air per minute for each occupant.
4. Remove all dust particles as these have been found to be vehicles for bacteria.
5. Remove all odors and gases.
6. Distribute the air within the room to create a desirable air turbulence without creating draughts.

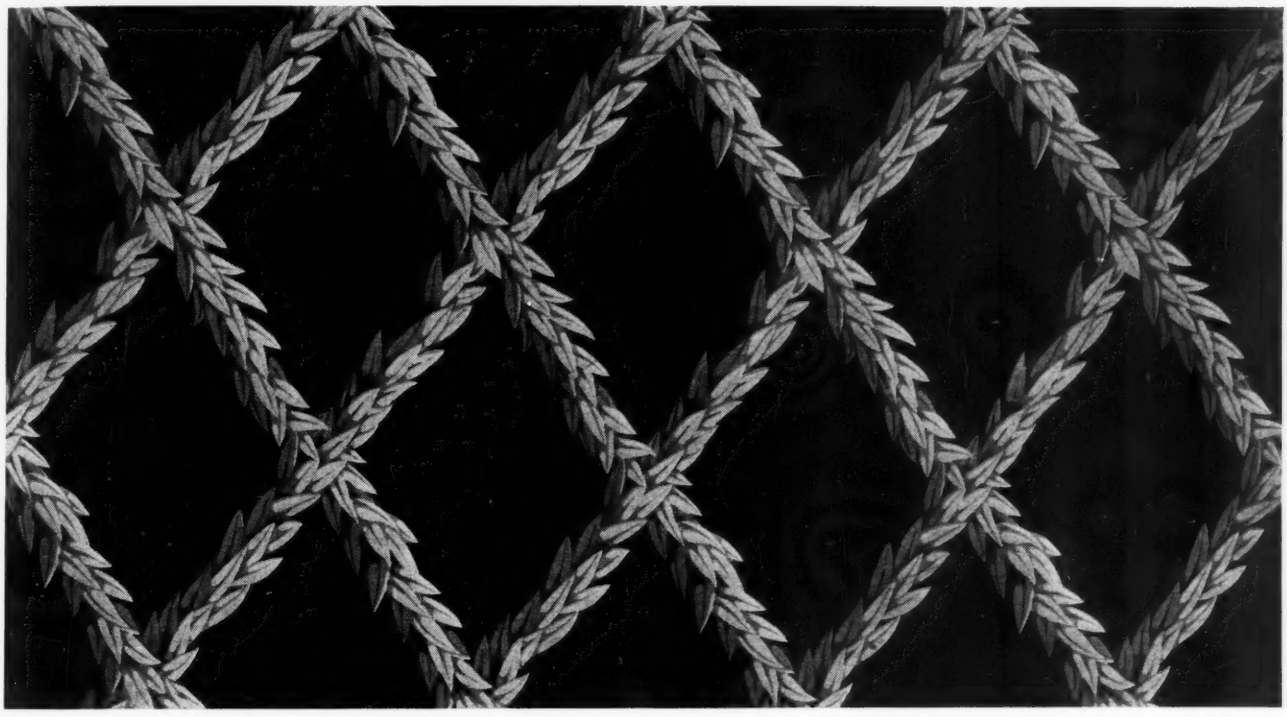
During the heating cycle it is necessary to perform the following functions:

1. Heat the air to the desired temperature.
2. Add considerable moisture to the air to raise the relative humidity.
3. Remove all dust and soot.
4. Distribute the air in such manner as to create a desirable turbulence without creating draughts.
5. Remove odors and gases.
6. Supply a minimum of one pound of fresh air a minute for each occupant.

For the heating cycle it has been found desirable to maintain the effective temperature about two degrees above that for cooling. When we consider all these functions necessary for air conditioning, it is obvious that older types of buildings would present a number of problems not found in a new structure, but so far the engineer has been able to design a variety of

THE NEW MOHAIR IS

TRIUMPHANT



FALL designs in Goodall-Sanford mohairs are specializing in verve. Take "TRIUMPH," shown here. Its bold print is calculated to sprout good spirits in the most listless patient. "TRIUMPH" is one of the new 50-inch mohair draperies which do not wrinkle, sag nor shrink. It is guaranteed sun-fast and tub-fast . . . It will give true "dyed-in-the-mohair" service, and 50 years of use has proved that it will outwear any and all other decorative fabrics. At your jobber; or a Chase salesman will spread out the whole new line.

Goodall-Sanford
INDUSTRIES

VELMO UPHOLSTERIES
GOODALL MOHAIRS

SEAMLOC CARPETS
LEATHERWOVE FABRICS

L. C. CHASE & CO., Inc., *selling division of Goodall-Sanford,* 295 Fifth Avenue, New York
BOSTON CHICAGO DETROIT SAN FRANCISCO

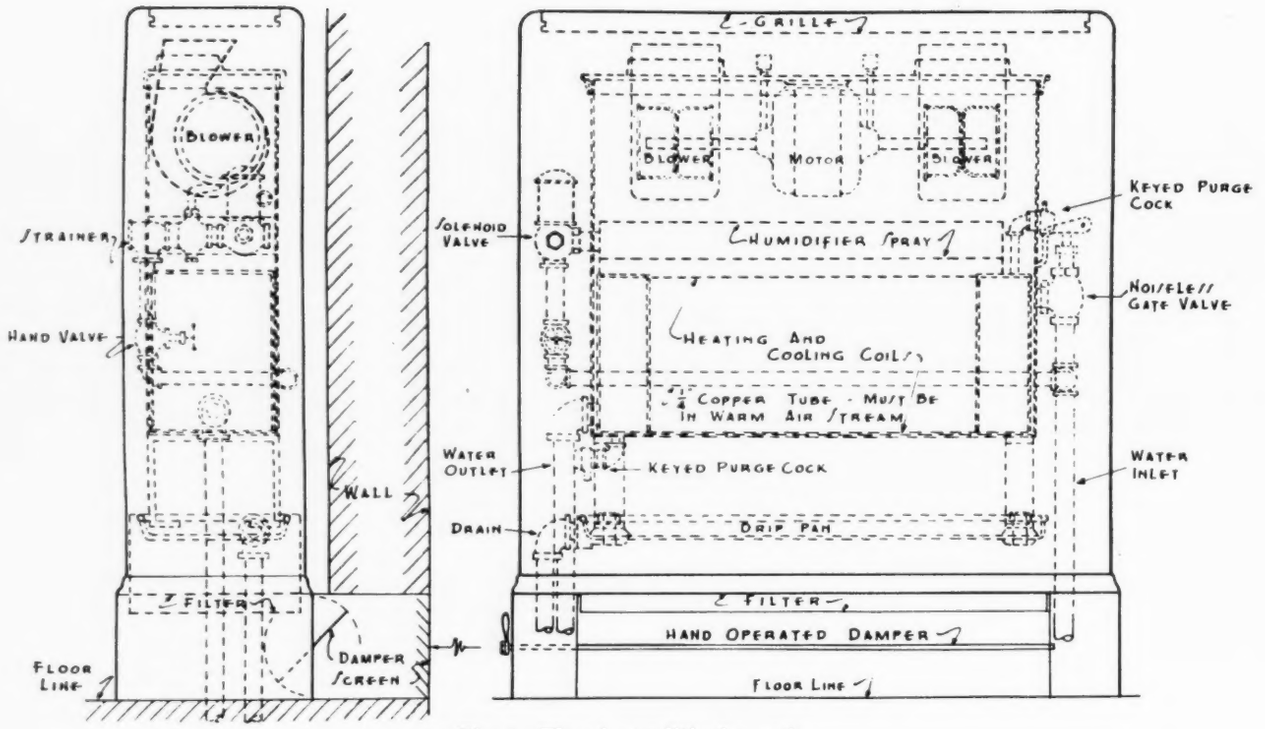


Fig. 1. The air conditioning unit.

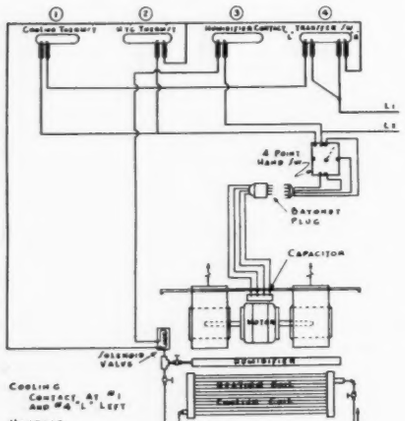


Fig. 2. Wiring diagram of unit conditioner.

equipment which makes the problem of equipping older buildings less expensive than was formerly thought possible.

Well insulated walls and windows are necessary to maintain the humidity necessary for air conditioning during the heating cycle. Without this insulation, the condensation on the outer walls and windows would be excessive and the heat less excessive. In fact it is difficult to maintain a humidity of 45 per cent in a poorly insulated room.

I have outlined some of the points to be considered in the use and application of air conditioning and will now give some specific data relative to the application of air conditioning to the operating rooms and nurseries at one of my hospitals now in process of construction.

The conditions to be met are as follows:

1. A relative humidity must be maintained at all times at 55 per cent or higher if explosive gases are being used for anesthesia. This is necessary to prevent any possibility of static sparks.

2. An individual conditioner unit for each operating room must be used so as not to transmit any air from one room to another.

3. The unit must be oversize in both heating and cooling capacity in order to prepare the room quickly for an operation.

4. The unit must be automatic in operation and capable of changing from the cooling to the heating cycle within a few minutes.

5. The unit must perform all of the functions of air conditioning and be provided with easily removable air filters.

6. All electric controls, switches and motors must be sparkproof.

7. The unit must be capable of hand

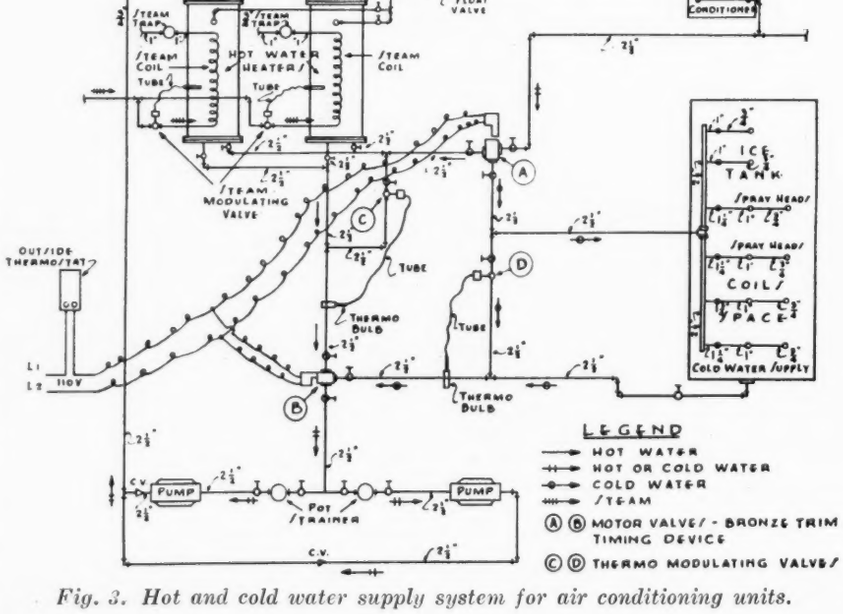
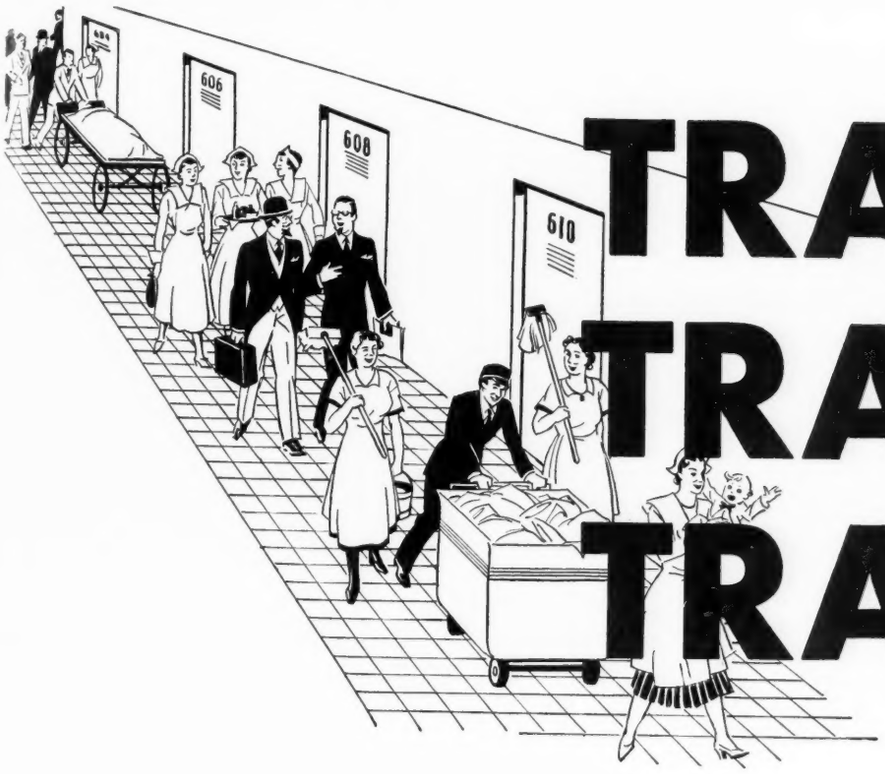


Fig. 3. Hot and cold water supply system for air conditioning units.



TRAMP! TRAMP! TRAMP!

Noisy Corridors Retard Recovery

GIVE PATIENTS QUIET WITH ACOUSTI-CELOTEX

There is hardly a medicine or a treatment so beneficial to every patient as that of soothing quiet.

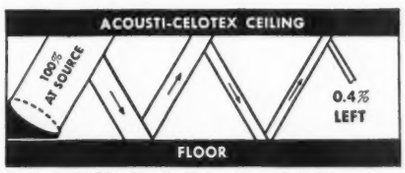
Nevertheless, hospitals are noisy, too noisy for the delicate process of recovery. How to stifle that noise, without stopping necessary activities, offers a real problem to hospital management.

The installation of Acousti-Celotex Sound Absorbing Tiles in the ceilings of corridors, kitchens, service rooms and other noise sources subdues nerve-irritating sounds at their very beginning, preventing their spread throughout the building and into patients' rooms.

Acousti-Celotex is economical to install and maintain. It may be left in its natural finish, or painted and repainted without loss of its sound absorbing efficiency. Pleasing and distinctive architectural patterns and decorative designs may be worked out.

Give your hospital the added advantage of quiet by installing Acousti-Celotex. Consult your local Acousti-Celotex contracting engineer for analysis, recommendations and estimates. Or write direct.

Noise spreads easily throughout a room with hard, sound-reflecting surfaces

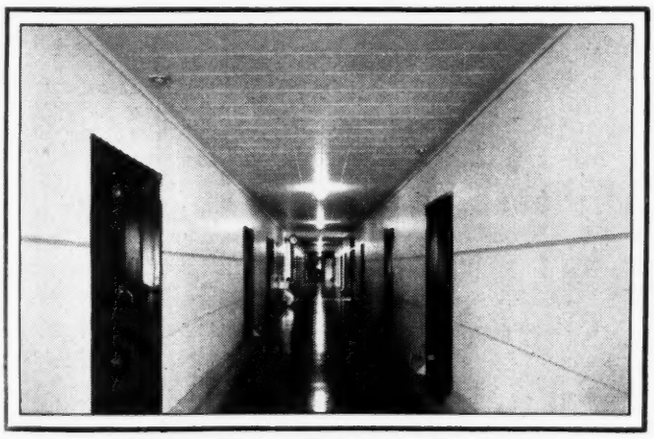


Noise is quickly absorbed by an Acousti-Celotex ceiling

• • •

Acousti-Celotex can now be furnished with a pre-painted, hard-finished surface especially adaptable to hospital installations.

THE CELOTEX COMPANY
919 No. Michigan Ave. Chicago, Ill.



University of Michigan Hospital, Ann Arbor, Michigan. Installation: Type B Acousti-Celotex

PAINTABLE ACOUSTI-CELOTEX PERMANENT

TRADE MARK REGISTERED U. S. PATENT OFFICE

operation as well as automatic operation.

8. The units must be able to supply fresh air as desired, as well as to recirculate the air.

9. An exhaust fan must be supplied to be operated in unison with the conditioner.

These requirements may seem complicated but really they are not so.

A special conditioning unit was designed which would operate on hot and cold water as the heating and cooling medium. A coil suitable for both heating and cooling is also provided so that we could cool properly with 45° F. (8° C.) water and heat properly with 160° F. (72° C.) water. Other requirements are a water spray for humidification, to operate only when the heating cycle is in operation; a ventilating wall box fitted with insect screens and dampers; space for a filter element to be thrown away after using; a wall panel; a drain to carry away the condensate.

Ice Used for Peak Conditions

The cold water supply from brine coils is supplemented by ice. The cooling season for this hospital will not exceed 100 days. This combination of ice and mechanical means for producing cold water is economical inasmuch as it allows the selection of a machine for the normal load and allows for the use of ice for the peak conditions, which are relatively few.

Alongside the cold water tank a heat exchanger is installed to provide the necessary hot water. This heating is done by steam coils immersed in the hot water tank and under automatic regulation to maintain the water temperature as desired.

If the weather should suddenly turn cold, as it often does in New England, a weather thermostat placed outside the building makes electrical contact which automatically shuts off the cold water from the circulating pump and turns on the hot water. It requires less than three minutes to change from the cooling cycle to the heating cycle. The same pump and the same piping are used for circulating both hot and cold water and motor valves simply operate to supply the pump with hot or cold water.

The system described allows for one set of piping and one set of radiation, which is less expensive than a double set of pipes.

Fig. 1, the conditioner unit, shows the various parts. Beginning at the top we have the outlet grille which directs the air at an angle of 15 degrees forward; directly under the grille is a twin blower with motor between. The humidifier sprays are separated from the blower by a vapor eliminator not shown. To the left is a salenoid valve which turns the sprays on and off according to need. The heating and cooling coil is of copper tubes with fins with a keyed valve at right to regulate the flow of water. Near the bottom is a drip pan to carry away the water from the sprays and condensate from the coil when cooling. The filter and air inlet damper is mounted in the base. The filter is a removable tray. The unit functions to cool, filter, heat, humidify, ventilate and dehumidify. The housing, filter, grille, blower assembly and sprays are all removable without the use of tools so as to permit thorough cleaning.

Fig. 2 shows the wiring diagram of the air conditioner. This gives electric control circuit at the unit. The operation is as follows: Transfer switch 4 is actuated by a temperature bulb in contact with water supply pipe at the coil. When hot water enters the coil the switch (4) makes contact on right "R" which places the heating control thermostat (2) in control of the motor and also places the humidostat (3) in operation as long as the water supply pipe is above 95 degrees. When cold water enters the coil the switch (4) throws to the left "L" position cutting out the humidostat (3) and thermostat (2) and closing the circuit to the cooling thermostat (1) and remains in this position while the unit is supplied with cold water. The four-point hand switch operates independently and is set for three motor speeds and off position. All these controls are mounted on a panel alongside the unit.

Hot and Cold Water Interchange

Fig. 3 shows the sequence of operation in connection with the interchange of hot and cold water. The operation is as follows: When the outdoor temperature drops to, say, 66 degrees the outside thermostat operates and causes the motor valve A—B to change positions so that the pump draws warm water from the hot water heater and thence to the units and returns via valve A to the hot water heater; trace the plain arrow marked hot water—beginning at pump discharge the water is pumped through the coil of the unit conditioner thence to valve A and thence to the hot water tank; if the water temperature entering the pump is too hot the thermo bulb operates valve C to allow the returning water to mix with hot water from the hot water heater. In this way the water temperature at the pump may be regulated as desired, say, 160 degrees, plus or minus 2 degrees. During this heating cycle the cold water tank is completely cut off.

When the outdoor temperature rises to, say, 78 degrees and cooling is desired, the outdoor thermostat operates to reverse the position of valves A—B so that the hot water supply is completely cut off and cold water passes to the pump. This cold water temperature is modulated by valve D attached to thermo bulb in cold water supply line. In this manner the cold water may be regulated to, say, 45 degrees, plus or minus 1 degree.

The cold water tank is fitted with ammonia coils in one end with clear space at the other end for dumping in two tons of ice to take care of peak load conditions. In this way a 15-ton machine will handle a 32-ton job. In tracing the hot and cold water circuit, note the legend arrows.[1]

[1]Read at the International Hospital Congress, Rome, Italy, May, 1935.

A Floor Testing Machine

A new and interesting machine for testing the wear-resisting qualities of floors and floor coverings was recently seen in one of the great industrial laboratories. This machine has been developed and built according to the techniques worked out by the United States Bureau of Standards. The various materials to be tested are cut wedge shape and are fitted into a large round surface, on a large flat disk, like the wedges of a pie.

This disk is then rotated and as it is rotated two large leather covered wheels, under 200 pounds' pressure, run along the outer edge. These wheels are, however, partially braked so that there is a certain amount of slippage. Thus, these leather bound wheels slipping along the outer edge of the disk duplicate the wearing action of leather shoes on the floors. All particles worn off are picked up by a vacuum cleaner attachment. A revolution counter records the total mileage of the test for purposes of comparison.

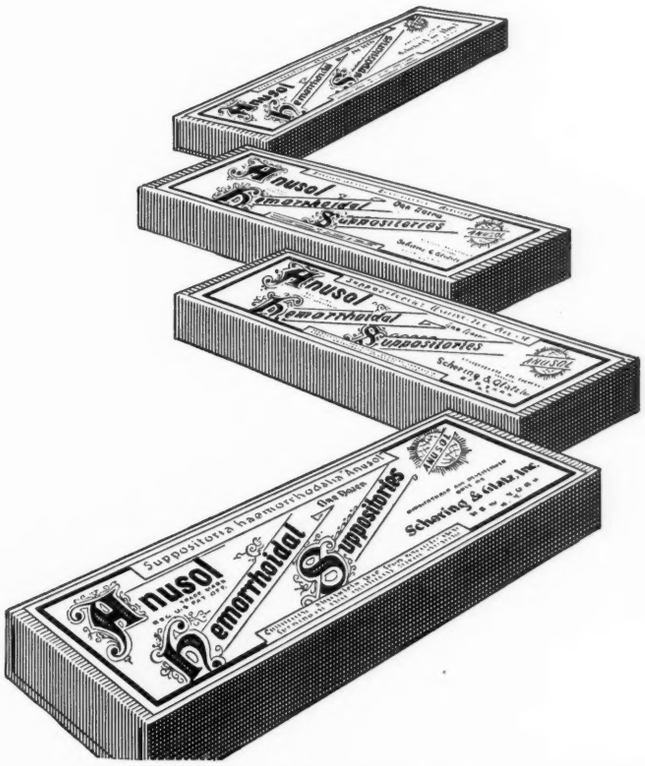
This is just one of the many new and interesting machines that have been developed for the purpose of testing the relative service value of many different items offered for the same purpose. With these machines the purchase of supplies may become scientific.

Grind and Wax Wooden Floors

The upkeep of wooden floors is a problem. They can, of course, be replaced with terrazzo which is expensive but permanent, or covered with one of several types of prefabricated floorings, less expensive but less permanent.

There is still another plan which has been followed at Michael Reese Hospital, Chicago, with good success. It was noticed that varnished floors soon became worn, because of the unevenness in the surface. For that reason floors were first surfaced by means of a surface grinder purchased for a little over $100. Stain was then applied and followed by two coats of varnish and a coat of wax. Floors are rewaxed about every sixty days.

The results have proved satisfactory. Initial cost is low, the appearance is good, and the life of the floors has been more than doubled by this treatment.



WHEN HEMORRHOIDS ARE PAINFUL

You can avoid the use of narcotic, analgesic or anesthetic drugs to relieve the pain caused by hemorrhoids—if you use Anusol Suppositories. These suppositories reduce the congestion that causes the pain, without the use of belladonna. When the congestion is gone, and the circulation is improved, there is less extravasation of blood. In such way, bleeding is controlled without styptics, ephedrine or epinephrine. There is no likelihood of unpleasant systemic effects.

In the non-surgical treatment of hemorrhoids, Anusol Suppositories have attained a reputation for dependability. And through many years they have held on to this prestige and greatly enhanced it.

We invite you to try Anusol Suppositories. A liberal supply sent on request.

SCHERING & GLATZ, Inc.
113 West 18th Street
New York City

ANUSOL

Anusol Suppositories are supplied in boxes of 6 and 12 suppositories. Special hospital package of 72 suppositories available. A suppository is used morning and evening, or more often. "Anusol" is the registered trade mark of Schering & Glatz.

FOOD SERVICE • • • •

Conducted by Anna E. Boller, Rush Medical College

Comparative Study of Raw Food Costs

By J. J. Weber

Superintendent, Vassar Brothers' Hospital, Poughkeepsie, N. Y.

THE increased cost to hospitals of consumable supplies during the past year led me to seek the cooperation of a group of hospital superintendents with whom I am closely associated in filling out a lengthy, detailed questionnaire in an effort to make as comprehensive a study as possible of the increasing cost of raw foodstuffs. It was thought that out of it might come some information that would be helpful to superintendents and dietitians in so modifying their menus as to assist them in keeping costs down to a minimum consistent with meeting the required balanced nutritional value in the meals they serve.

The participating hospitals were asked to indicate opposite the names of the various food commodities they purchased the total units they purchased in the first three months of 1934 and 1935; the cost of the total units purchased in the first three months of these two years and to indicate in a remarks column brands, make, size. They were further asked to give the distribution of the total meals served in the first three months of 1934 and 1935 and to answer the following questions:

Do you bake your own bread, rolls, pastry, or do you buy these under contract?

Do you make your own ice cream or do you buy it?

How often each week do you serve ice cream throughout the hospital?

Do you buy your coffee in bulk or in packages?

Do you buy ground coffee or do you have it ground in the hospital?

The figures in these questionnaires were then totaled and analyzed in order to secure the following information:

The total cost of various raw foods purchased during the first three months of 1934.

The total cost of various raw foods purchased during the first three months of 1935.

Comparative increase or decrease in these costs to the various hospitals.

Raw food costs per 100 meals during the first three months of 1934.

Raw food costs per 100 meals during the first three months of 1935.

Increase or decrease in the raw food costs per 100 meals.

These figures are set forth in the tabulation headed "Summary of Questionnaire on Raw Food Costs," which appears on the following pages.

We were able to break down certain of the main classifications, notably meats, into their subdivisions to good advantage. Other main classifications, however, such as groceries, could not well be broken down.

A Basis for Comparison

Should any hospital superintendent or dietitian be sufficiently interested in doing so, he or she could readily make a comparison of the figures in the accompanying tabulations with his costs by making the same calculations that were made by the ten hospitals which cooperated in this study.

A study of these figures, especially for meats, comparing them with the figures of any other hospital should enable the hospital executive in cooperation with his dietitian to determine whether food costs can be advantageously reduced by the more frequent use of one kind of raw food in preference to some other more expensive kind.

Some of the participating hospitals were not specific as to the grades of food they are using but where this information was given it is indicated in the supplementary notes. The brands of canned goods and groceries are so varied that no generalization could be made in regard to them.

A tabulation of the various types of meals served by the different participating hospitals, insofar as this information is indicated, is given below.

KEY TO HOSPITALS

Hospital A — A community hospital of 250 beds in a New England city of 162,000 population, about seventy-five miles from New York.

Hospital B — A community hospital of 370 beds in a Great Lakes city of 570,000 population.

Hospital C — A community hospital of 285 beds in a New York State city of 96,000 population.

Hospital D — A large public county hospital of 903 beds in the New York metropolitan area.

Hospital E — A small community hospital of 108 beds within seventy-five miles of New York City.

Hospital F — A community hospital of 391 beds in a suburban city in New Jersey.

Hospital G — A community hospital of 272 beds in an industrial city of 137,000 population in New Jersey.

Hospital H — A community hospital of 234 beds in the borough of Brooklyn, New York City.

Hospital I — A community hospital of 225 beds in a city of 45,000 population, seventy-five miles from New York City.

Hospital J — A community hospital of 185 beds in an industrial city above Albany, N. Y.

DISTRIBUTION OF TOTAL MEALS SERVED IN FIRST THREE MONTHS OF 1934 AND 1935

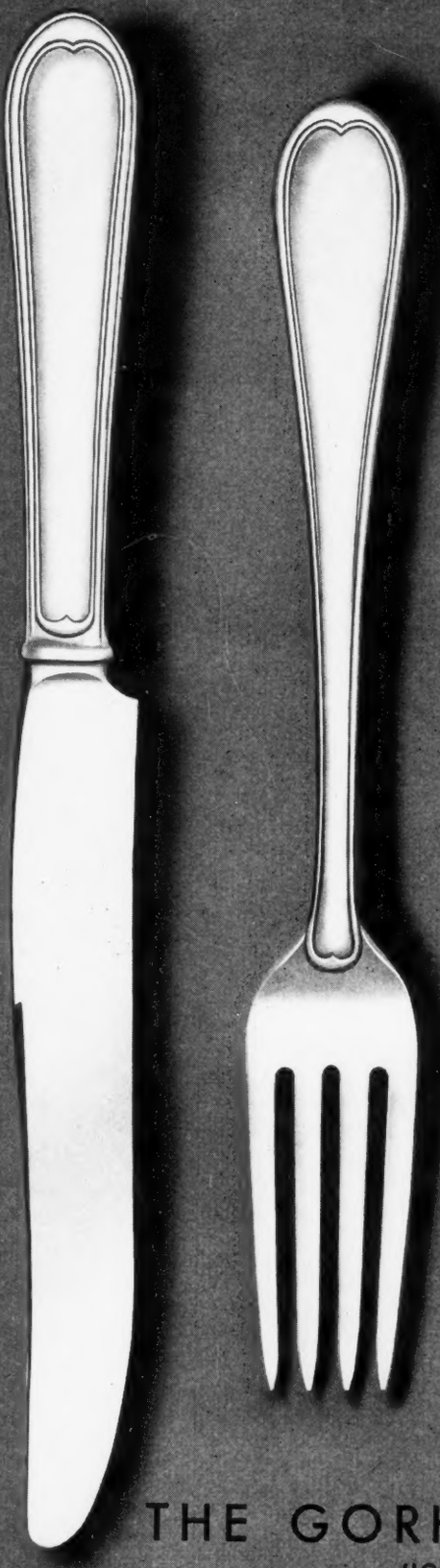
Hospital	*House Meals**		*Patients' Meals Regular*		*Patients' Meals Special Diets*		*Patients' Meals Formulas*		*Guests' Meals*	
	1934	*1935*	*1934*	*1935*	*1934*	*1935*	*1934*	*1935*	*1934*	*1935*
A	68,898	69,593	50,997	46,728	.....	.....	.....	.....	.....	.....
B	54,468	57,295	43,976	44,867	2,362	2,635	.....	.....	80	95
C	48,847	52,488	45,292	48,261	9,480	8,502	1,961	1,962	No account kept	
D	193,089	197,720	115,815	107,247	33,156	41,678	32,967	29,251	5,262	7,760
E	17,033	17,536	9,514	8,424	2,402	2,105	448	497	No account kept	
F	74,871	76,746	42,310	41,821	6,977	4,941	1,050	1,070	No account kept	
G	52,431	51,624	39,192	42,877	3,478	5,099	503	749	No account kept	
H	70,830	70,830	41,061	41,695	4,029	4,385	Aver. 18 Daily	Aver. 18 Daily	150	153
I	42,290	42,162	28,401	29,106	5,849	4,838	1,098	735	31	30
J	37,060	34,534	24,188	20,082	3,297	4,521	444	471	8	65

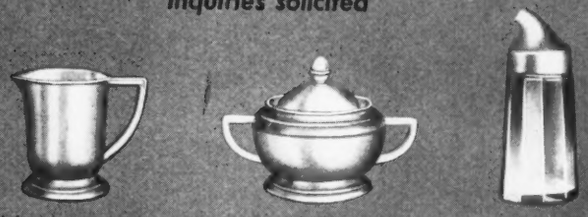
*Includes meals served employees, resident and attending doctors, special nurses and student nurses.

Brittany
by Gorham

A French provincial pattern of simplicity and grace, commends itself for its massive weight and lack of ornamentation. It is practical to the last degree and should meet with merited success with users of hospital silverware. PRICES CONSISTENT WITH QUALITY

Inquiries solicited





THE GORHAM COMPANY

HOSPITAL DIVISION

CHICAGO
10 South Wabash Avenue

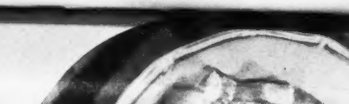
NEW YORK
6 West 48th Street

SAN FRANCISCO
972 Mission Street

Summary of Questionnaire on Raw Food Costs

	1st 3 mos.	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Hospital H	Hospital I	Hospital J
Meat, Poultry and Fish											
Beef											
Total Cost	1934	$1,180.13	$ 441.57	$ 926.48	$2,442.88	$ 326.99	$1,134.05	$1,343.89	$1,070.97	$ 671.22	$ 974.21
Total Cost	1935	1,413.90	845.18	1,540.05	3,736.75	371.44	1,188.25	1,725.86	1,205.08	870.39	1,186.97
Increase in Cost		233.77	403.61	613.57	1,293.87	44.45	54.20	381.97	134.11	199.17	212.76
Cost per 100 meals	1934	.9840	.4377	.8774	.6424	1.1123	.9057	1.4056	.9225	.8642	1.4988
Cost per 100 meals	1935	1.2155	.8057	1.3846	.9739	1.3004	.9538	1.7198	1.0292	1.1323	1.9891
Increased cost per 100 meals		.2315	.3680	.5072	.3315	.1881	.0481	.3142	.1067	.2681	.4903
Veal											
Total Cost	1934	193.29	134.46	216.16	609.00	95.70	134.86	416.11	192.16	252.58	23.76
Total Cost	1935	216.88	379.94	315.90	695.51	47.90	134.46	534.80	264.06	294.82	164.17
Increase in Cost		23.59	245.48	99.74	86.51	*– 47.80	– .40	118.69	71.90	42.24	140.41
Cost per 100 meals	1934	.1613	.1333	.2047	.1601	.3255	.1077	.4353	.1655	.3252	.0365
Cost per 100 meals	1935	.1865	.3622	.2840	.1812	.1677	.1079	.5329	.2255	.3836	.2751
Increased cost per 100 meals		.0252	.2289	.0793	.0211	– .1578	.0002	.0976	.0600	.0584	.2386
Lamb											
Total Cost	1934	384.09	218.25	319.58	1,201.29	49.87	538.16	820.82	364.02	314.02	429.45
Total Cost	1935	392.54	279.96	351.40	1,556.62	68.15	613.54	850.36	532.72	370.98	471.97
Increase in Cost		8.45	61.71	31.82	355.33	18.28	75.38	29.54	168.70	56.96	42.52
Cost per 100 meals	1934	.3204	.2163	.3026	.3159	.1696	.4298	.8585	.3136	.4043	.6607
Cost per 100 meals	1935	.3374	.2669	.3159	.4057	.2386	.4924	.8474	.4550	.4826	.7909
Increased cost per 100 meals		.0170	.0506	.0133	.0898	.0690	.0626	– .0111	.1414	.0783	.1302
Pork, fresh											
Total Cost	1934	169.23	284.80	252.13	990.68	69.34	97.04	196.21	262.95	88.02	125.94
Total Cost	1935	286.26	460.24	446.46	1,223.13	137.30	210.73	35.14	289.48	204.55	93.06
Increase in Cost		117.03	175.44	194.33	232.45	67.96	113.69	– 161.07	26.53	116.53	– 32.88
Cost per 100 meals	1934	.1412	.2823	.2388	.2605	.2358	.0775	.2052	.2265	.1133	.1937
Cost per 100 meals	1935	.2461	.4388	.4014	.3188	.4807	.1691	.0350	.2472	.2660	.1559
Increased cost per 100 meals		.1049	.1565	.1626	.0583	.2449	.0916	– .1702	.0207	.1527	– .0378
Pork, cured											
Total Cost	1934	713.67	650.70	580.02	1,484.32	208.78	609.92	436.12	326.12	661.24	513.74
Total Cost	1935	838.22	904.93	902.54	2,352.19	284.03	647.86	606.12	495.35	950.60	715.77
Increase in Cost		124.55	254.23	322.52	867.87	75.25	37.94	170.00	169.23	289.36	202.03
Cost per 100 meals	1934	.5952	.6449	.5493	.3903	.7102	.4871	.4561	.2809	.8513	.7904
Cost per 100 meals	1935	.7206	.8627	.8115	.6130	.9944	.5200	.6040	.4230	1.2364	1.1994
Increased cost per 100 meals		.1254	.2178	.2622	.2227	.2842	.0329	.1479	.1421	.3851	.4090
Poultry											
Total Cost	1934	1,016.25	809.26	305.73	1,866.58	331.19	825.80	1,351.35	980.68	606.20	285.54
Total Cost	1935	1,313.34	1,318.88	650.07	2,805.35	314.54	888.89	1,343.31	1,062.25	913.98	330.42
Increase in cost		297.09	509.62	344.34	938.77	– 16.65	63.09	– 8.04	81.57	307.78	44.88
Cost per 100 meals	1934	.8477	.8021	.2895	.4908	1.1266	.6587	1.4134	.8448	.7804	.4393
Cost per 100 meals	1935	1.1291	1.2574	.5845	.7312	1.1012	.7127	1.3386	.9072	1.1889	.5537
Increased cost per 100 meals		.2814	.4553	.2950	.2404	– .0254	.0540	– .0748	.0624	.4085	.1144
Fish											
Total Cost	1934	411.86	289.69	216.87	724.82	109.72	495.44	576.97	543.74	292.80	334.97
Total Cost	1935	409.49	305.81	292.46	729.71	62.56	531.61	484.66	442.89	236.14	298.36
Increase in Cost		– 2.37	16.12	75.59	4.89	– 47.16	36.17	– 92.31	– 100.85	– 56.66	– 36.61
Cost per 100 meals	1934	.3435	.2872	.2054	.1906	.3732	.3956	.6034	.4683	.3769	.5153
Cost per 100 meals	1935	.3520	.2915	.2629	.1901	.2190	.4267	.4829	.3782	.3071	.4999
Increased cost per 100 meals		.0085	.0043	.0575	– .0005	– .1542	.0311	– .1205	– .0901	– .0698	– .0154
Miscellaneous											
Total Cost	1934	94.42	122.18	91.19	89.86	9.78	57.28	155.48	146.71	100.00	23.56
Total Cost	1935	113.25	158.95	56.49	275.22	31.99	119.20	220.58	123.77	98.68	39.31
Increase in Cost		18.83	36.77	– 34.70	185.36	22.21	61.92	65.10	– 22.94	– 1.32	15.75
Cost per 100 meals	1934	.0788	.1211	.0863	.0236	.0329	.0456	.1626	.1263	.1287	.0362
Cost per 100 meals	1935	.0974	.1515	.0507	.0717	.1120	.0956	.2198	.1057	.1283	.0658
Increased cost per 100 meals		.0186	.0304	– .0356	.0481	.0791	.0500	.0572	– .0206	– .0004	.0296
Total of Division											
Total Cost	1934	4,162.94	2,950.91	2,908.16	9,409.43	1,201.37	3,892.55	5,296.95	3,887.35	2,986.08	2,711.17
Total Cost	1935	4,983.88	4,653.89	4,555.37	13,374.48	1,317.91	4,334.54	5,800.83	4,415.60	3,940.14	3,300.03
Increase in Cost		820.94	1,702.98	1,647.21	3,965.05	116.54	441.99	503.88	528.25	954.06	588.86
Cost per 100 meals	1934	3.4721	2.9249	2.7540	2.4742	4.0861	3.1077	5.5401	3.3484	3.8443	4.1709
Cost per 100 meals	1935	4.2846	4.4367	4.0955	3.4856	4.6140	3.4782	5.7804	3.7710	5.1252	5.5298
Increased cost per 100 meals		.8125	1.5118	1.3415	1.0114	.5279	.3705	.2403	.4226	1.2809	1.3589

*—equals decrease.
Undesignated equals increase.



THE GENE
s and broil
Juice to bo
with cold wa
's too Fine
es, Pickles,
Alaska Sa
or institutio
accepted by
of the Ameri

Libb
in Es
Featu
trays
body
For
field-t
carryi
and re
Mo
expect
is a go
miner
values
You
usual
ordina
N-57,

A change that perks 'em up! + + +

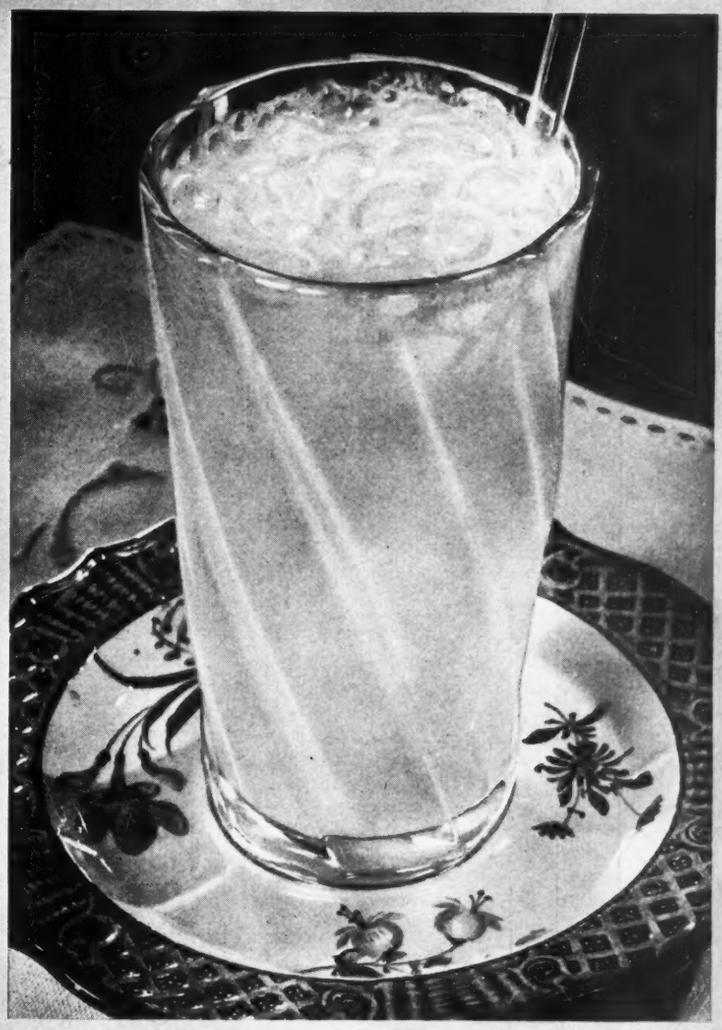
FOR BREAKFAST, AND OTHER MEALS

Libby's *unsweetened* Pineapple Juice . . . rich in Esters. Something different in a breakfast drink! Feature Libby's Hawaiian Pineapple Juice on your trays . . . in the staff dining-room . . . and everybody's pleased!

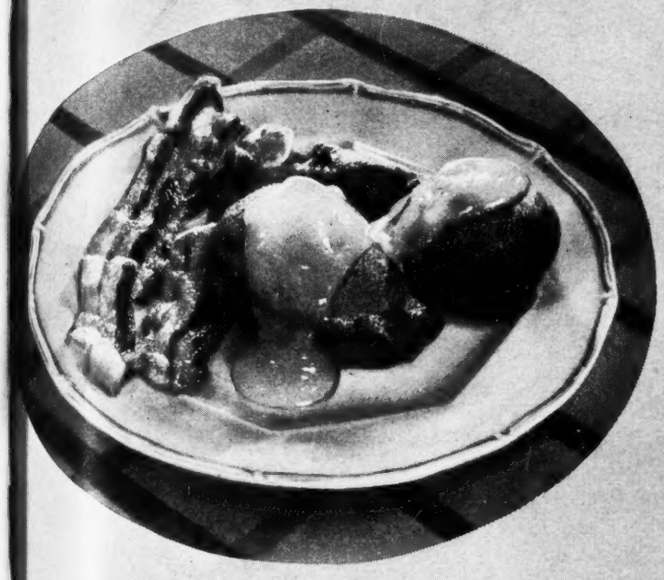
For Libby's is the natural, *unsweetened* juice of field-ripened Hawaiian pineapple. Rich in the flavor-carrying Esters of the full-ripe fruit, it has a glorious and refreshing tang!

Moreover, Libby's furnishes all the vitamins expected of a fruit juice. It contains Vitamin A, and is a good source of B and C. It supplies alkali-forming minerals and other nutritional essentials. And these values are uniform the year around.

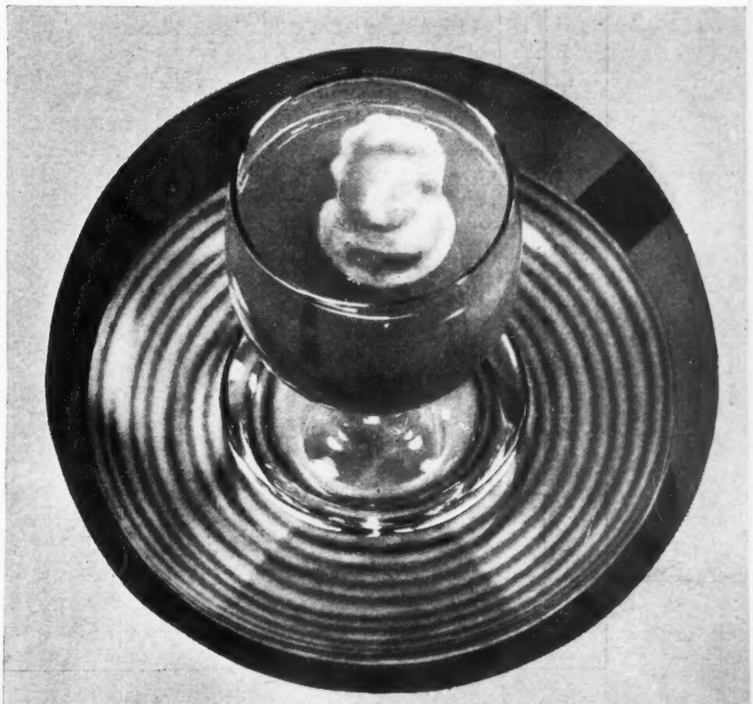
You can get Libby's Pineapple Juice from your usual source of supply. It costs you no more than ordinary brands. Libby, McNeill & Libby, Dept. N-57, Welfare Building, Chicago.



FOR THE LIQUID DIET . . . A frothy Pineapple Milk Shake is a refreshing and nutritious change. Combine Libby's Hawaiian Pineapple Juice with lemon juice, ice water, sugar. Stir until sugar is dissolved. Add to chilled Libby's Evaporated Milk and shake with crushed ice. Libby's Pineapple Juice is most appetizing served plain, too.



THE GENERAL DIET . . . Pineapple Sauce enhances a tempting dish of hot
s and broiled bacon for luncheon or supper. Heat Libby's Hawaiian Pine-
Juice to boiling. Sift equal portions of cornstarch and sugar together and
with cold water to make a paste. Add to boiling liquid and cook ten minutes.



FOR THE SOFT DIET . . . Pineapple Gelatin with Whipped Cream has a zesty flavor. To make it, combine orange gelatin with Libby's Hawaiian Pineapple Juice and sugar. Chill the jelly until set and garnish with whipped cream before serving. You'll find that Libby's Pineapple Juice improves many bland desserts.

's 100 Fine Foods include Fruits and Fruit Juices, Veg-
es, Pickles, Condiments, Canned Meats, Evaporated
, Alaska Salmon. Each comes in regular and special
or institutions. In addition, Libby packs Homogenized
Foods for Babies

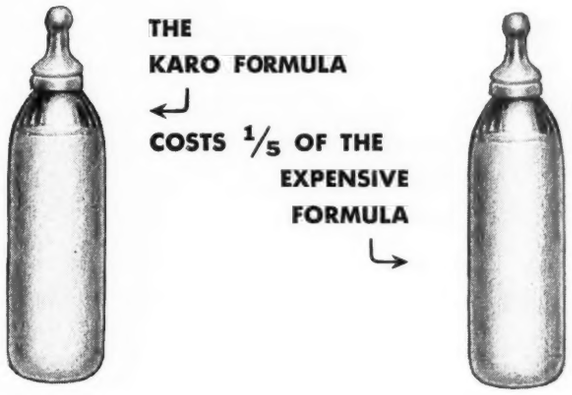
Accepted by the Committee on Foods of the American Medical Association

Summary of Questionnaire on Raw Food Costs *(Cont.)*

	1st 3 mos.	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Hospital H	Hospital I	Hospital J
Eggs, Cheese and Nuts											
Eggs											
Total Cost	1934	639.00	596.32	424.70	3,547.43	204.54	969.50	1,430.50	1,153.23	750.30	451.50
Total Cost	1935	1,286.10	547.60	820.04	3,817.05	391.17	1,268.45	1,706.95	1,184.55	775.50	507.07
Increase in cost		647.10	− 48.72	395.34	269.62	186.63	298.95	276.45	31.32	25.20	55.57
Cost per 100 meals	1934	.5330	.5911	.4023	.9328	.6958	.7743	1.4963	.9934	.9660	.6945
Cost per 100 meals	1935	1.1056	.5221	.7374	.9949	1.3695	1.0182	1.7010	1.0117	1.0088	.8497
Increased cost per 100 meals		.5726	− .0690	.3351	.0621	.6737	.2439	.2047	.0183	.0428	.1552
Cheese											
Total Cost	1934	105.98	62.37	105.56	119.16	11.20	85.77	76.18	92.65	29.15	58.36
Total Cost	1935	93.49	80.77	69.37	163.83	27.23	126.02	83.31	76.46	40.87	58.86
Increase in Cost		12.49	18.40	− 36.19	44.67	16.03	40.25	7.13	− 16.19	11.72	.50
Cost per 100 meals	1934	.0884	.0618	.1000	.031	.0381	.0685	.0797	.0798	.0375	.0898
Cost per 100 meals	1935	.0804	.0770	.0623	.042	.0953	.1011	.0830	.0653	.0532	.0986
Increased cost per 100 meals		.0080	.0152	− .0377	.0114	.0572	.0326	.0033	− .0145	.0157	.0088
Nuts											
Total Cost	1934	59.60	4.41	12.30	.....	2.50	4.30	30.00	5.28	12.30	19.35
Total Cost	1935	84.04	7.23	23.80	.....	2.25	17.20	27.15	2.75	16.40	11.50
Increase in Cost		24.44	2.82	11.50	.....	− .25	12.90	− 2.85	− 2.53	4.10	− 7.85
Cost per 100 meals	1934	.0497	.0044	.0116	.....	.0085	.0034	.0314	.0045	.0158	.0298
Cost per 100 meals	1935	.0722	.0069	.0214	.....	.0079	.0138	.0271	.0023	.0213	.0193
Increased cost per 100 meals		.0225	.0025	.0098	.....	− .0006	.0104	− .0043	− .0022	.0055	− .0105
Total of Division											
Total Cost	1934	804.58	663.10	542.56	3,666.59	218.24	1,059.57	1,536.68	1,251.16	791 75	529.21
Total Cost	1935	1,463.63	635.60	913.21	3,980.88	420.65	1,411.67	1,817.41	1,263.76	832.77	577.43
Increase in Cost		659.05	− 27.50	370.65	314.29	202.41	352.10	280.73	12.60	41.02	48.22
Cost per 100 meals	1934	.6711	.6573	.5139	.9641	.7424	.8462	1.6074	1.0777	1.0193	.8141
Cost per 100 meals	1935	1.2582	.6060	.8211	1.0376	1.4727	1.1331	1.8111	1.0793	1.0833	.9676
Increased cost per 100 meals		.5871	− .0513	.3072	.0735	.7303	.2869	.2037	.0016	.0640	.1535
Butter, Oil and Shortenings											
Butter											
Total Cost	1934	1,126.18	921.54	904.37	2,864.94	247.71	1,116.10	1,273.04	1,262.70	805.52	545.64
Total Cost	1935	1,504.18	1,706.62	1,108.68	4,330.15	308.02	1,693.24	1,758.64	1,645.82	1,167.70	750.78
Increase in Cost		378.00	785.08	204.31	1,465.21	60.31	577.14	485.60	383.12	362.18	205.14
Cost per 100 meals	1934	.9393	.9134	.8566	.7534	.8426	.8914	1.3316	1.0966	1.0371	.8395
Cost per 100 meals	1935	1.2932	1.6270	.9969	1.1286	1.0784	1.3592	1.7525	1.4057	1.5190	1.2582
Increased cost per 100 meals		.3539	.7136	.1403	.3752	.2358	.45[illegible]	.4209	.3091	.4819	.4187
Oils											
Total Cost	1934	73.50	36.97	35.15	114.80	13.50	34.80	52.50	144.00	82.60	37.80
Total Cost	1935	143.75	47.50	72.85	131.60	21.00	86.05	112.65	147.00	73.95	55.55
Increase in Cost		70.25	10.53	37.70	16.80	7.50	51.25	60.15	3.00	8.65	17.75
Cost per 100 meals	1934	.0613	.0367	.0333	.0302	.0459	.0278	.0549	.0452	.1063	.0582
Cost per 100 meals	1935	.1236	.0453	.0655	.0344	.0735	.0691	.1122	.1256	.0962	.0931
Increased cost per 100 meals		.0623	.0086	.0322	.0042	.0276	.0413	.0573	.0804	− .0101	.0349
Shortening											
Total Cost	1934	30.10	.....	17.66	276.98	17.33	89.50	51.03	34.40	52.00	25.30
Total Cost	1935	66.40	57.00	77.81	379.50	9.90	240.25	122.33	42.00	55.75	61.93
Increase in Cost		36.30	57.00	60.15	102.52	− 7.43	150.75	71.30	7.60	3.75	36.63
Cost per 100 meals	1934	.0251	.....	.0167	.0728	.0589	.0715	.0534	.0439	.0670	.0389
Cost per 100 meals	1935	.0570	.0543	.0700	.0989	.0346	.1928	.1219	.0359	.0725	.1038
Increased cost per 100 meals		.0319	.0543	.0533	.0261	− .0243	.1213	.0685	− .0080	.0055	.0649
Total of Division											
Total Cost	1934	1,229.78	958.51	957.18	3,256.72	278.54	1,240.40	1,376.57	1,441.10	940.12	608.74
Total Cost	1935	1,714.33	1,811.12	1,259.34	4,841.25	338.92	2,019.54	1,993.62	1,834.82	1,297.40	868.26
Increase in Cost		484.55	852.61	302.16	1,584.53	60.38	779.14	617.05	393.72	357.28	259.52
Cost per 100 meals	1934	1.0257	.9501	.9066	.8564	.9474	.9907	1.4399	1.1857	1.2104	.9366
Cost per 100 meals	1935	1.4738	1.7266	1.1324	1.2619	1.1865	1.6211	1.9866	1.5672	1.6877	1.4551
Increased cost per 100 meals		.4481	.7765	.2258	.4055	.2391	.6204	54.67	.3815	.4773	.5185
Milk, Cream and Ice Cream											
Milk											
Total Cost	1934	1,887.00	1,622.40	1,622.98	10,031.35	498.20	2,506.83	1,827.06	1,858.37	1,183.37	1,110.66
Total Cost	1935	2,087.95	1,571.92	2,795.04	9,211.82	494.77	2,465.47	1,465.71	1,947.40	1,297.90	917.24
Increase in Cost		200.95	− 50.48	1,172.06	− 819.53	− 3.43	− 41.36	− 361.35	89.03	114.53	− 193.42
Cost per 100 meals	1934	1.5739	1.6081	1.5372	2.6378	1.6947	2.0021	1.9111	1.6008	1.5236	1.7088
Cost per 100 meals	1935	1.7950	1.4986	2.5132	2.4010	1.7322	1.9790	1.4606	1.6634	1.6884	1.5371
Increased cost per 100 meals		.2211	− .1095	.9760	− .2368	− .0375	− .0231	− .4505	.0626	.1648	− .1717

COMPARE *these*

CARBOHYDRATE COSTS



Composition - - - - - the same
Quality - - - - - - - the same
Quantity - - - - - - the same
Results - - - - - - - the same

Doctor! Help the family out of the economic dilemma. You brought good milk within the means of every American baby. Now add *Karo Syrup as the milk modifier.* Karo Syrup is essentially Dextrins, Maltose and Dextrose, with a small percentage of Sucrose added for flavor.

Choose Karo as the way out of expensive carbohydrates and slash the high cost of infant feedings. Prescribe the formula for the baby *and the budget.* The baby will thrive, the mother will save, the doctor will collect.

Karo is also the carbohydrate of choice because it is well tolerated, readily digested, effectively utilized. Karo does not cloy the appetite, produce fermentation or disturb digestion. Keep the baby on Karo.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept. **H-10** *, 17 Battery Place, New York City*

Summary of Questionnaire on Raw Food Costs *(Cont.)*

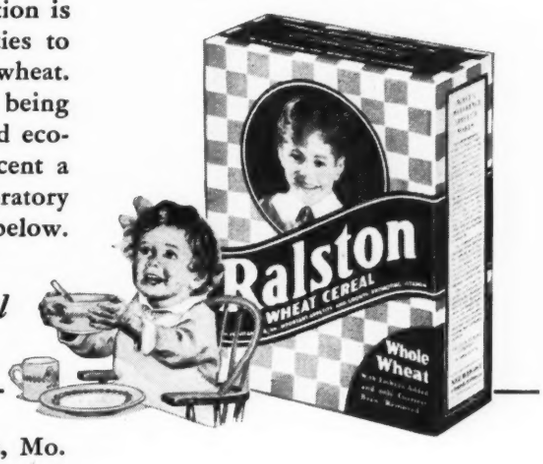
	1st 3 mos.	*Hospital A*	*Hospital B*	*Hospital C*	*Hospital D*	*Hospital E*	*Hospital F*	*Hospital G*	*Hospital H*	*Hospital I*	*Hospital J*
Cream											
Total Cost	1934	604.45	1,296.00	194.40	174.15	258.36	360.65	314.44	362.26	278.50	440.00
Total Cost	1935	825.24	1,306.05	192.06	157.20	285.56	289.65	247.32	425.20	275.22	431.40
Increase in Cost		220.79	10.05	− 2.34	− 16.95	27.20	− 71.00	− 67.12	62.94	− 3.28	− 8.60
Cost per 100 meals	1934	.5041	1.2846	.1841	.0458	.8789	.2880	.3289	.3121	.3586	.6770
Cost per 100 meals	1935	.7094	1.2451	.1727	.0410	.9998	.2325	.2465	.3631	.3580	.7230
Increased cost per 100 meals		.2053	− .0395	− .0114	− .0048	.1209	− .0555	− .0824	.0510	− .0006	.0460
Evaporated Milk											
Total Cost	1934	35.91	112.40	66.00	59.25	7.05	81.50	56.70	84.80	40.75	6.86
Total Cost	1935	26.70	167.25	142.50	19.48	12.09	43.24	11.60	105.77	48.60	11.55
Increase in Cost		− 9.21	54.85	76.50	− 39.77	5.04	− 38.26	− 45.10	20.97	7.85	4.69
Cost per 100 meals	1934	.0300	.1114	.0625	.0156	.0239	.0651	.0593	.0730	.0525	.0105
Cost per 100 meals	1935	.0229	.1594	.1281	.0051	.0423	.0347	.0115	.0903	.0632	.0194
Increased cost per 100 meals		− .0071	.0480	.0656	− .0105	.0184	− .0304	− .0478	.0173	.0107	.0089
Ice Cream											
Total Cost	1934	452.69	390.00	743.40	953.60	19.76	419.67	598.40	.....	588.25	.....
Total Cost	1935	509.00	414.00	757.40	868.49	74.56	463.40	544.00	.....	472.50	.....
Increase in Cost		56.31	24.00	14.00	− 85.11	54.80	43.73	− 54.40	.....	− 115.75	.....
Cost per 100 meals	1934	.3776	.3866	.7041	.2508	.0672	.3352	.6259	.....	.7187	.....
Cost per 100 meals	1935	.4376	.3948	.6810	.2264	.2611	.3720	.5421	.....	.6147	.....
Increased cost per 100 meals		.0600	.0082	− .0231	− .0244	.1939	.0368	− .0838	.....	− .1050	.....
Total of Division											
Total Cost	1934	2,980.05	3,420.80	2,626.78	11,218.35	783.37	3,368.65	2,796.60	2,305.43	2,060.87	1,557.52
Total Cost	1935	3,448.89	3,459.22	3,887.00	10,256.99	866.98	3,261.76	2,268.63	2,478.37	2,094.22	1,360.19
Increase in Cost		468.84	38.42	1,260.22	− 961.36	83.61	− 106.89	− 527.97	172.94	33.35	− 197.33
Cost per 100 meals	1934	2.4856	3.3907	2.4879	2.9500	2.6647	2.6904	2.9252	1.9859	2.6534	2.3963
Cost per 100 meals	1935	2.9649	3.2979	3.4950	2.6735	3.0354	2.6182	2.2607	2.1168	2.7243	2.2795
Increased cost per 100 meals		.4793	− .0928	1.0071	− .2765	.3707	− .0722	− .6645	.1309	.0709	− 11.68
Bread											
Total Cost	1934	518.88	678.41	797.34	1,256.11	175.98	501.46	735.14	892.14	618.14	484.71
Total Cost	1935	516.54	593.29	847.19	993.77	194.27	594.56	686.04	689.75	509.70	452.87
Increase in Cost		− 2.34	− 85.21	49.85	− 262.34	18.29	93.10	− 49.10	− 202.39	− 108.44	− 31.84
Cost per 100 meals	1934	.4327	.6725	.7552	.3303	.5986	.4005	.7689	.7685	.7956	.7457
Cost per 100 meals	1935	.4446	.5656	.7617	.2590	.6801	.4772	.6836	.5891	.6629	.7589
Increased cost per 100 meals		.0119	− .1069	.0065	− .0713	.0815	.0767	− .0853	− .1794	− .1327	.0132
Fruits and Vegetables, fresh											
Total Cost	1934	2,459.58	2,094.68	1,628.22	5,559.58	477.86	2,777.58	2,287.53	1,874.75	1,353.17	929.63
Total Cost	1935	2,406.53	1,936.43	1,285.80	4,195.12	541.87	2,401.43	1,926.98	1,527.48	1,251.45	710.38
Increase in Cost		− 53.05	− 158.25	− 342.42	− 1,364.46	64.01	− 376.15	− 360.55	− 347.27	− 101.72	− 219.25
Cost per 100 meals	1934	2.0515	2.0762	1.5421	1.4619	1.6255	2.2183	2.3927	1.6150	1.7422	1.4456
Cost per 100 meals	1935	2.0689	1.8461	1.1561	1.0934	1.8971	1.9276	1.9202	1.3046	1.6279	1.1904
Increased cost per 100 meals		.0174	− .2301	− .3860	− .3685	.2716	− .2907	− .4725	− .3104	− .1143	− .2552
Fruits and Vegetables, canned											
Total Cost	1934	1,667.43	1,557.67	1,555.92	3,759.30	392.45	1,481.10	1,060.07	1,103.46	1,167.61	1,117.40
Total Cost	1935	1,734.73	955.33	1,506.36	3,749.09	328.87	1,552.90	1,147.41	1,161.01	1,190.83	1,534.44
Increase in Cost		67.30	− 602.34	− 49.56	− 10.21	− 63.58	71.80	87.34	57.55	23.22	417.04
Cost per 100 meals	1934	1.3907	1.5437	1.4736	.9885	1.3354	1.1829	1.1088	.9496	1.5033	1.7191
Cost per 100 meals	1935	1.4913	.9107	1.3544	.9772	1.1514	1.2465	1.1434	.9916	1.5491	2.5611
Increased cost per 100 meals		.1006	− .6330	− .1192	− .0113	− .1840	− .0636	.0346	.0420	.0458	.8420
Groceries											
Total Cost	1934	1,357.94	1,452.47	1,147.86	2,342.29	458.42	1,270.03	1,164.21	955.42	828.17	857.15
Total Cost	1935	1,432.85	1,317.40	1,314.94	2,613.01	359.17	1,240.65	1,096.26	956.62	1,082.87	819.08
Increase in Cost		74.91	− 135.07	167.08	270.72	− 99.25	− 29.38	− 67.95	1.20	254.70	− 38.07
Cost per 100 meals	1934	1.1326	1.4397	1.0871	.6159	1.5594	1.0143	1.2177	.8230	1.0662	1.3187
Cost per 100 meals	1935	1.2318	1.2599	1.1823	.6810	1.2575	.9958	1.0924	.8170	1.4112	1.3558
Increased cost per 100 meals		.0992	− .1798	.0952	.0651	− .3019	− .0185	− .1253	− .0060	.3450	.0371
Total of Raw Food Supplies											
Total Cost	1934	15,181.18	13,776.55	12,164.02	40,468.37	3,986.23	15,591.34	16,253.75	13,710.81	10,745.91	8,795.53
Total Cost	1935	17,701.38	15,362.28	15,569.21	44,004.59	4,368.64	16,817.05	16,737.18	14,327.41	12,199.38	9,622.68
Increase in Cost		2,520.20	1,585.73	3,405.19	3,536.22	382.41	1,225.71	483.43	616.60	1,453.47	827.15
Cost per 100 meals	1934	12.6620	13.6551	11.5204	10.6413	13.5595	12.4510	17.0007	11.7538	13.8347	13.5470
Cost per 100 meals	1935	15.2181	14.6495	13.9985	11.4692	15.2947	13.4977	16.6784	12.2366	15.8716	16.0982
Increased cost per 100 meals		2.5561	.9944	2.4781	.8279	1.7352	1.0467	.3223	.4828	2.0369	2.5512

The child who is a FEEDING PROBLEM

Children who won't eat—America's young hunger strikers—are legion, as every doctor knows. Very frequently their poor appetites, their nervousness and irritability are all due to this one fact: *Their diets do not provide vitamin B in sufficient quantities to meet the demands of an active, growing body.*

Ralston Wheat Cereal can help you correct or prevent such deficiencies easily, quickly, pleasantly. For Ralston not only supplies all the good of choice whole wheat (only coarsest bran removed) but in addition is enriched with wheat germ in sufficient quantities to make it 2½ times richer in vitamin B than whole wheat. Ralston, moreover, has the extra advantage of being a hot, cooked cereal. It is both convenient and economical—cooks quickly, costs less than one cent a serving. For FREE samples and the Research Laboratory Report on Ralston Wheat Cereal, use the coupon below.

2½ times richer in vitamin B



RALSTON —*The Hot Cereal Children Love*

RALSTON PURINA COMPANY
Dept. MH, 136 Checkerboard Square, St. Louis, Mo.
Please send me a copy of your Research Laboratory Report and samples of Ralston Wheat Cereal.

Name_____

Address_____

(This offer limited to residents of the United States)

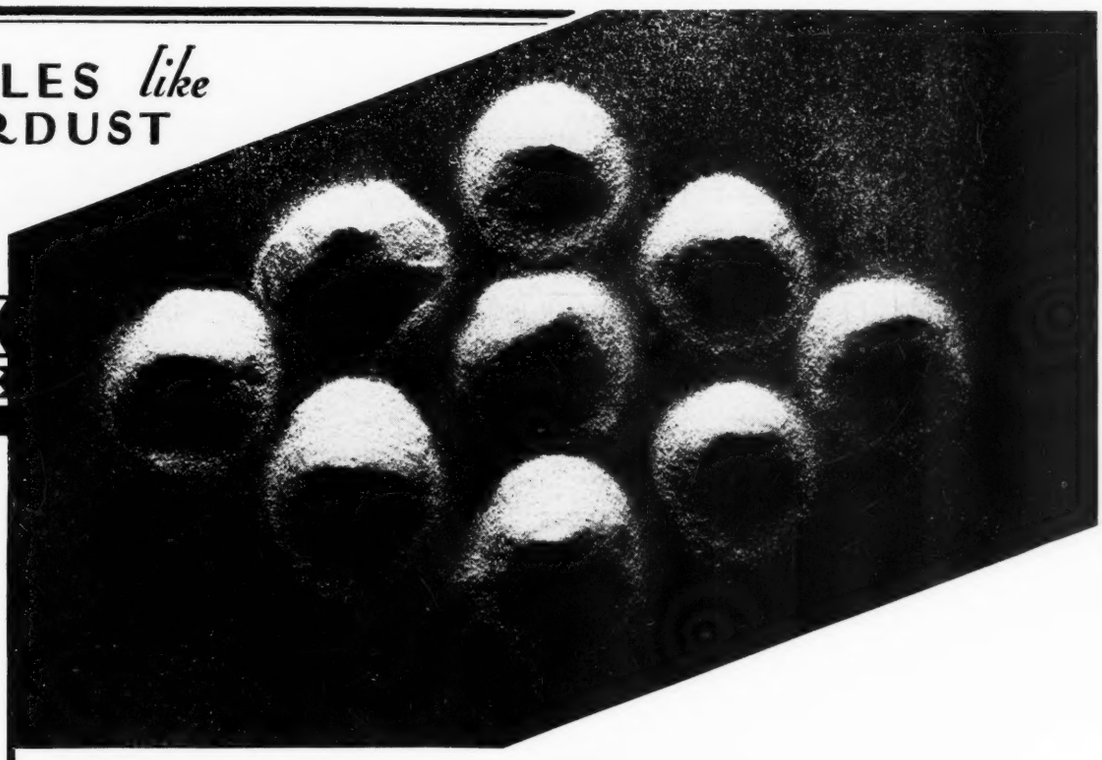
Types of Raw Food Purchased by Ten Hospitals

Food	*Hospital A*	*Hospital B*	*Hospital C*	*Hospital D*	*Hospital E*
Beef	Legs—medium. Ribs and loins—fancy. Corned beef—brisket.	Government graded—"Good." Ribs, tenderloins (G.G. "Choice") Wt. 6-8 lbs. dried beef, liver.	All meats cut due to lack of space and equipment. Top round, chuck, prime ribs, loins, dried and corned beef (rump) liver (sliced yearling).	Carcass and liver.	Hinds, forequarters, ribs, loins, hamburg ground.
Veal	Carcass—90-100 lbs. average Western dressed. Hindquarters—Legs, short.	Government graded—"Choice." Carcass and in 1935 some saddles.	Racks, legs, chuck (boneless veal).	Carcass.	Hindquarters (saddles)
Lamb	Carcass and backs—spring.	Carcass Government graded—"Choice."	Carcass, racks, legs and a little chuck.	Carcass.	Racks and legs.
Pork—Fresh	Loins—10-12 lb. aver. Spare ribs and fresh liver.	Shoulders.	Hams and loins.	Carcass.	Hams and loins.
Pork—Cured	Skinless 14-16 lb. average hams, sliced rindless bacon, sausage in hog casings.	Hams, bacon, sausage.	Hams, bacon and sausage.	Hams and bacon.	Hams, bacon and sausage.
Miscellaneous	Calves' sweetbreads, calves' liver, bologna, frankfurters, liverwurst, veal loaf and salami.	Sweetbreads, liver and frankfurters.	Frankfurters, sweetbreads and tripe.	Calves' liver and in 1935 frankfurters.	Frankfurters and in 1935 some calves' liver.
Poultry		All poultry fresh killed—no box poultry used. Buy fowl and broilers—no roasters or fryers.	Roasting chickens and fowl—no fryers or broilers.	Roasting chickens only.	Fowl and in 1935 some broilers.
Eggs	Strictly fresh, medium, storage.		Strictly fresh A's; also in 1935 some B's.	Only strictly fresh.	
Butter	Prints—92 plus score. Tub —90 plus score.	All butter 92 score.			¼ lb. print butter only.
Milk	Mainly Grade B in bulk; some Grade A and Grade B bottled.		Bulk Grade A, a little Grade B.		Bulk and some Grade A.
Bread	Bake own rolls and pastry; buy bread.	Bake own pastry; buy bread and rolls.	Buy bread, rolls and cakes; bake pastry.	Bake own bread, rolls, pastry, etc.	Buy bread; bake pastry and some rolls.
Nuts	Shelled.				
Vegetables		Only fresh fruits and vegetables used on special diets.			
Ice Cream	Buy it. Serve daily to private patients on request; once or twice weekly throughout hospital.	Make own. Served three times each week throughout hospital.	Buy all ice cream. Served three times weekly in summer and two times in winter throughout hospital.	Buy mixture, then freeze. Served twice weekly throughout hospital.	Mostly made at hospital. Served once a week throughout hospital.
Coffee	Bought in 1 lb. packages, ground.	In bulk—put up in weighed packages for each unit. Buy ground coffee freshly roasted each week.	In 1 lb. packages, ground.	In bulk, ground.	In bulk, fresh roasted beans, ground at hospital.

Food	*Hospital F*	*Hospital G*	*Hospital H*	*Hospital I*	*Hospital J*
Beef	Rounds, hips. Toward latter 1934 discontinued. Buying shell loins and hindquarters; substituting hips and rounds.	Hinds, sides, ribs (8 cut) and loins of prime quality, dried beef, smoked knuckles and tongues, brisket for corning.	Sides of Texas steers, average 400 lbs. wh., hinds, few loins, liver, corned beef.	Hinds, ribs, forequarters, rounds in 1934, loins in 1935, dried beef, liver in 1935. Good or choice quality.[1]	Hinds, ribs, pot roast, dried beef all A-1 grade; also beef stew meat and in 1935 hips of beef; no loins in 1935.
Veal	Legs and forequarters; now buys cheaper cuts and discontinues use of legs.	Hindquarters (saddles) city dressed.	Legs—first milk-fed.	Hindquarters and some legs in 1935. Eastern good or choice quality—legs 40-50 lbs.	Hindquarters (saddles).
Lamb	Chucks, backs, legs and liver. Now buys cheaper cuts—more chuck, less legs, fewer chops.	Hind saddles, city dressed.	Carcass, racks and legs—spring.	Saddles, racks, liver, spring, good or choice—long hind saddles 28-35 lbs., racks double 4-6 lbs., backs 12 lbs.	Racks and legs—A-1 grade.
Pork—Fresh	Hams and loins, no shoulders or spareribs.	Spareribs—no loins in 1935.	Hams (first), loins.	Shoulders, fewer loins in 1935, hams and spareribs in 1935, hams 10-12 lbs., loins 8-10 lbs.	Grade A-1 loins only.
Pork—Cured	Hams (decreased in 1935 because too expensive) bacon (decreased 1935) sausage.	Hams, bacon, special squares, sausage (breakfast).	Premium hams and bacon, sausage and in 1935 some smoked tenderloin.	Hams, less bacon in 1935, sausage and salt pork. Hams 12-14 lbs., bacon 10-12 lbs.	Grade A-1 hams; less bacon in 1935 more sausage.
Miscellaneous		Sweetbreads, fresh calves' liver, first quality frankfurters and chow mein.	Frankfurters, boiled ham, bologna and liverwurst.	Sweetbreads, calves' liver, frankfurters and liverloaf.	Small amount calves' liver, more frankfurters in 1934; no sweetbreads.

[1]Hinds, 170-180 lbs.; ribs, N. Y. Cert., 32-40 lbs.; ribs, Boston Cert., 50-60 lbs.; rounds without flanks, 50-60 lbs.

SPARKLES *like* STARDUST



KNOX SCIENTIFIC FACTS

Solutions of Knox Gelatine are filtered and concentrated in vacuo. Even the air used for drying is filtered.

•

Analysis Knox Gelatine

Protein (14 amino acids)	85.0—86.0%
Calcium Phosphate	1.0—1.25%
Fat (Less than)	0.1%
Moisture	13.0—14.0%
Carbohydrates	Nil

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

Bacteriologically safe... pH of about 6.0... odorless... no carbohydrates ... made as carefully as an ampule solution.

Of interest in the treatment of muscular dystrophy is the 25% glycine in Knox Gelatine.

GELATINE U.S.P. in Diarrhea ... A Low Residue Food

GELATINE U. S. P. is almost completely and so readily absorbed after ingestion, with practically no further stimulation of intestinal muscles, that it is being widely used in the treatment of diarrhea.

Knox Sparkling Gelatine affords even less residue than U. S. P. Gelatine. It exceeds in quality all U. S. P. standards. Sensitive peristaltic muscles are not burdened by added irritation. What's more, the colloidal properties of Knox Gelatine, when used as a vehicle for other foods, lend protective, emulsoid aid.

A most remarkable product—Knox Gelatine. For the convalescent, tubercular, high-protein, post-operative, diabetic and infant diet where higher protein content is desirable.

KNOX SPARKLING GELATINE

KNOX GELATINE LABORATORIES, 465 Knox Avenue, Johnstown, N. Y.

Please send me FREE your booklets, "Feeding Sick Patients," "Feeding Diabetic Patients" and "Reducing Diets."

Name.....

Address.....

City.....*State*.....

TYPES OF RAW FOOD PURCHASED BY TEN HOSPITALS *(Cont.)*

Food	*Hospital F*	*Hospital G*	*Hospital H*	*Hospital I*	*Hospital J*
Poultry	Roasting chickens, fowl and a few broilers. Increased use of turkey because cuts to better advantage.	Roasting chickens and fowl (Grade A); some broilers (Grade A).	Milk-fed fowl; also fryers which are used for roasting and smothering. Milk-fed broilers.	Roasting chicken, fowl, fryers. Roasting chickens—4¼-5 lbs. Fowl,—4¼-5 lbs. Fryers—2½-3 lbs.	Fowl only.
Eggs	Strictly fresh and frozen. Increased in 1935 for meat substitutes.	Strictly fresh, Grade A whites.	Strictly fresh, Grade A.	Strictly fresh; bought a few storage eggs in 1934.	Strictly fresh only.
Butter	1-lb. prints only; use increased in 1935 due to increased vegetable plates.	¼ lb. prints and tubs, both 93 plus score.	1 lb. prints.	In ¼ lb. prints; also cooking butter.	1 lb. prints only; use broken squares for cooking.
Milk		Grade B pasteurized; Grade A for children's ward and baby formulas.	Mostly Grade B bulk; some Grade A and certified vitamin D.	Mostly bulk milk Grade B pasteurized; some Grade A.	Mostly Grade A; no Grade B in 1935; some certified raw.
Bread	Buy bread, rolls, pastry not on contract.	Buy bread, rolls, pastry under contract.	Bread and rolls on contract; bake pastries.	Bread and rolls on contract; make own pastries.	Bread and rolls under contract; bake own pies, cakes and muffins.
Nuts					
Vegetables					
Ice Cream	Buy it. Served once a day to private patients; twice a week throughout hospital.	Make own ice cream. Served three times a week throughout hospital.	Make own. Served twice weekly.	Buys it. Served throughout hospital three times weekly in 1934; 2.5 times weekly in 1935.	Make own; served twice a week.
Coffee	1-lb. packages, ground—dated 12-14 days old.	100 lb. bags in bean, ground by hospital.	Packages, ground.	1-lb. packages, ground.	1-lb. packages, ground.

FOOD FOR THOUGHT

• Guest trays are proving popular with visitors, and are actually proving a source of income. Helen Markley, at the Cooper Hospital, Camden, N. J., served 123 such trays in one month, and the total receipts were $95. Breakfast and supper are served for 75 cents each, and dinner for $1. Toast and coffee are served for 25 cents when requested.

• The question of the size of a cracker has always been a problem in deciding the number that can be substituted for a slice of bread. The changing of the size of the ordinary soda cracker will make it necessary to change the proportions that are suggested in the diabetic clinic. It has become necessary to weigh each type of cracker and establish new figures for each one. Roughly speaking, we can say that it takes four of the smaller crackers to equal three of the old ones.

• "Man's place in future history will depend in no small degree on what he eats," is the statement of Dr. James S. McLester, Birmingham, Ala., outgoing president of the American Medical Association. Scientists have pointed the way for man to be master of his own destiny. Longer life, larger stature, greater vigor and a higher level of cultural attainment are available for those who will take advantage of our present knowledge of nutrition. People must be taught the foods to eat, and they must be assured an adequate supply, thus throwing the responsibility in making man attain this mastery on the government. Doctor McLester stated that the lack of food is going to affect the health of the nation unless the government does something to control this economic aspect.

• The lowly spareribs and sauerkraut come into their own! Dr. C. H. Best and associates of the University of Toronto have brought out that the benefit of taking large quantities of sauerkraut are derived from its lactic acid and choline (the new vitamin) content, the latter having been found necessary for normal function of the liver.

• There has been a question as to where the Chinese get their calcium. Pik Wan Hoh of the Oregon State College, threw some light on the subject some time ago when she found that one serving of a Chinese dish furnished .55 of a gram of calcium. She attributed this high calcium content to the action of the acid that was added in the preparation of the dish.

Dr. Jessamine Chapman Williams, of the same institution, has carried the work further, according to her report presented at the recent meeting of the Home Economics Association. She determined the calcium content of meat cooked with acid sufficiently dilute so that it does not flavor the meat, as does the acid used in Chinese dishes. Her preliminary report showed that the calcium content of meat dishes can be greatly increased in this way. Final reports of this work may change many ideas in regard to meat cookery — the lowly stew may come into its own!

• By the way, vitamin C has changed its name. The official name for crystalline vitamin C is now cevitamic acid, instead of ascorbic acid. Dr. I. S. Wright, in the proceedings of the Society of Experimental Biology in Medicine, tells of the capillary tests for special clinical scurvy and states that he believes that cevitamic acid may be used in the treatment of scurvy without causing irritation to the gastro-intestinal tract in patients with colitis or ulcers. Doctor Alvarez also mentioned this in his editorial. He suggests buying vitamins in concentrated form in the drug store, rather than eating too much roughage to obtain the same amount. This suggestion is made not only for cases of sensitive gastro-intestinal tracts, but also for normal individuals where large doses are needed, to prevent the starting of some irritation.

• A survey of food prices by the U. S. Bureau of Labor Statistics shows that flour, eggs, chickens and meat have all advanced at about the same rate in the last two years.

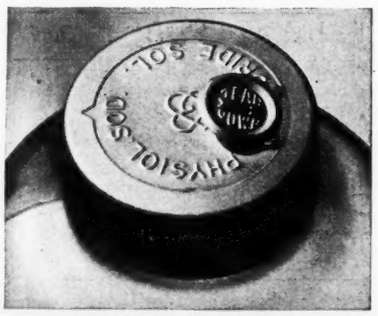
	June 1933	*June 1935*	*% Increase 1933-1935*
Flour (per lb.)	3.4c	5.0c	48
Hens (per lb.)	21.4c	30.2c	45
Eggs (per doz.)	20.0c	32.0c	60
Round of beef (per lb.)	25.8c	37.7c	48

• A nice piece of original research has been presented in a booklet, "The Nutritive Value of California Prunes." Anyone who has not seen it, will agree with Dr. Langley Porter of the University of California Medical School, who says in the foreword, "I had no idea that so much well devised research had been done on prunes."

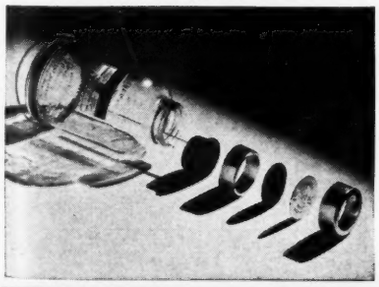
ACCEPTED AMERICAN MEDICAL ASSN

*First . . . TO GIVE YOU A NEW, METAL, TAMPER-PROOF SEAL

Patented beyond all ability to copy

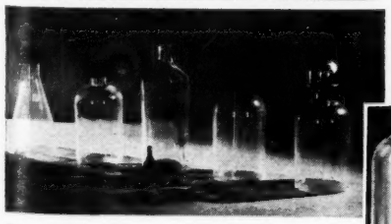


Unretouched photograph showing Baxter's new tamper-proof, metal seal.



Baxter's new Vacoliter seal completely eliminates the often-times stubborn screw cap; making it quicker and easier to prepare for administration.

**Journal of the American Medical Association, Vol. 105, No. 9, page 56.*



Photograph of the six earlier Baxter containers. Showing the progressive developments in the evolution of the new and improved Vacoliter.

This is the original Vacoliter that revolutionized the science of intravenous therapy . . . now offered to you in an improved form.

. . . And FIRST to give you a permanently attached bail on *each* Vacoliter

Your intravenous solution problems engage the attention of Baxter technicians every day in the year. During the last twelve months Baxter's engineers have worked to perfect for you, a metal, tamper-proof container, superior to any other type of seal.

They discovered that many types of seals offered, complicated the administration procedure by adding one more operation. Baxter, however, offers a new metal, tamper-proof seal that actually simplifies the technique of preparing for administration, by completely eliminating the often-times stubborn screw cap.

Baxter . . . the first to provide you with positive, tamper-proof protection, gives you a seal that may be easily removed.

The metal identification disc is removed, then the rubber diaphragm is removed aseptically as before. Formerly at this point it was necessary to replace the old style black screw cap but this is eliminated by the use of an inner metal pressed-on seal.

The *new* Baxter closure is a thoroughly scientific development—safer and more convenient. We respectfully urge you to test Baxter's *new* tamper-proof seal with any other that may be offered to you and see for yourself its obvious superiority.

BAXTER LABORATORIES, Inc.

GLENVIEW, ILL. **GLENDALE, CALIF.**

Tomac

Distributed East of the Rockies by

AMERICAN HOSPITAL SUPPLY CORPORATION

Merchandise Mart, CHICAGO **315 Fourth Ave., NEW YORK**

November Dinner Menus for the Staff*

By AMY COLESCOTT
Formerly Dietitian, Indianapolis City Hospital, Indianapolis

Day	Soup or Appetizer	Meat, Fish or Substitute	Potato or Substitute	Vegetable	Salad or Relish	Dessert
1.	Split Pea Soup	Fried Halibut, Tartar Sauce	Parsley Potatoes	Buttered Spinach	Pickle Chips	Lemon Pie
2.	Vegetable Soup	Beef Patties	Julienne Potatoes	Harvard Beets	Asparagus Salad, French Dressing	Favorite Pudding, Hard Sauce
3.	Cranberry Cocktail	Roast Chicken With Celery Dressing	Mashed Sweet Potatoes	Buttered Peas	Apricot and Cottage Cheese Salad	Peppermint Candy Ice Cream
4.	Bouillon	Arabian Pork Chops	Mashed Potatoes	Breaded Tomatoes	Stuffed Celery	Brown Apple Betty
5.	Grapefruit Juice Cocktail	Roast Lamb, Mint Sauce	Baked Idaho Potatoes	Buttered String Beans	Marinated Vegetable	Date Torte
6.	Consommé With Noodles	Broiled Steaks, Mushroom Sauce	French Fried Potatoes	Mashed Turnip	Peach and Coconut Salad	Apple Pie With Cheese
7.	Creole Soup	Braised Sweetbreads	Lyonnaise Potatoes	Buttered Fresh Spinach	Grapefruit and Orange Section Salad	Mock Plum Pudding
8.	Cream of Carrot Soup	Fried Perch	Parsley Potatoes	Stewed Tomatoes and Celery	Vegetable Salad	Peach Pie
9.	Sauerkraut Juice Cocktail	Fried Fresh Ham	Whipped Potatoes	Buttered Rutabaga	Head Lettuce, French Dressing	Brownies and Red Cherry Sauce
10.	Clear Tomato Soup	Roast Rib of Beef Au Jus	Browned Potatoes	Buttered Cauliflower	Cranberry Salad	Pineapple Upside Down Cake
11.	Fruit Cocktail	Chicken à la King	Shoe String Potatoes	Baked Hubbard Squash	Celery Hearts and Olives	Bread and Raisin Pudding, Vanilla Sauce
12.	Vegetable Soup	Fried Liver	Creamed Potatoes	Fried Onions	Golden Glow Salad	Devil's Food Cake
13.	Grape Juice Cocktail	Boiled Fresh Tongue, Horseradish Sauce	Escalloped Potatoes	Buttered Fresh Spinach	Argyle Salad	Chocolate Blancmange and Cream
14.	Beef Broth With Barley	Lamb Chops	Rissolé Potatoes	Buttered String Beans	Tomato Aspic Salad	Stuffed Baked Apples
15.	Cream of Spinach Soup	Baked Salmon, Lemon Garnish	Parsley Potatoes	Creamed Celery	Head Lettuce, Thousand Island Dressing	Apricot and Pineapple Pie
16.	Brown Onion Soup	Pot Roast of Beef	Noodles	Glazed Carrots	Vegetable Salad	Spanish Cream
17.	Tomato Juice Cocktail	Chicken Fricassée With Hot Biscuits	Steamed Rice	Buttered Peas	Celery Cabbage Salad, French Dressing	Banana Cake
18.	Chicken Soup	Liver and Bacon	Creamed Potatoes	Buttered String Beans	Stuffed Prune and Cheese Salad	Cherry Cobbler
19.	Noodle Soup	Meat Loaf, Tomato Sauce	Escalloped Potatoes	Baked Hubbard Squash	Cabbage Salad	Cream Rice Pudding
20.	Grapefruit Juice Cocktail	Beef à la Mode	Oven Fried Potatoes	Buttered Kale	Peach and Browned Coconut Salad	Butterscotch Tart
21.	Cream of Celery Soup	Roast Lamb, Mint Sauce	Rissolé Potatoes	Buttered Peas and Carrots	Cranberry Salad	Jellied Pears
22.	Creole Soup	Broiled Minute Steaks	Baked Potatoes	Creamed Onions	Orange, Date and Nut Salad	Blueberry Pie
23.	Vegetable Soup	Swiss Pork Steak	Whipped Potatoes	Escalloped Tomatoes	Perfection Salad	Baked Apples With Cream
24.	Fruit Cocktail	Veal Birds	Au Gratin Potatoes	Buttered Cauliflower	Sunbright Salad, Cooked Dressing	Peach Halves and Cookies
25.	Cream of Vegetable Soup	Baked Virginia Ham	Escalloped Sweet Potatoes and Apples	Buttered String Beans	Head Lettuce, Russian Dressing	Baked Custard
26.	Beef Broth	Pot Roast of Beef, American Style	Boiled Potatoes	Boiled Carrots	Waldorf Salad	Steamed Chocolate Pudding, Hard Sauce
27.	Pineapple Juice Cocktail	Broiled Steaks	French Fried Potatoes	Mashed Rutabaga	Mixed Fruit Salad	Bread and Raisin Pudding, Vanilla Sauce
28.	Consommé	Roast Turkey With Chestnut Dressing	Glazed Sweet Potatoes	Buttered Brussels Sprouts	Cranberry Sauce, Dressed Lettuce Salad	Hot Mince Pie
29.	Tomato Juice Cocktail	Fried Catfish, Lemon Garnish	Mashed Potatoes	Buttered Spinach	Grapefruit and Orange Section Salad	Lady Baltimore Cake
30.	Bouillon	Roast Veal	Browned Potatoes	Buttered Peas	Celery Cabbage Salad	Fruit Gelatin, Custard Sauce

*Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

A GREAT HELP IN MANY DIETS . . . THIS CHEESE FOOD THAT'S DIGESTIBLE AS MILK ITSELF!

● You will find Velveeta a great help in getting *variety* into both convalescent and special diets. For this appetizing cheese food with the rich, mild Cheddar flavor may be served sliced or spread, toasted, in cooked dishes, or melted to a smooth sauce.

Nutritional data: Velveeta is a cheese food mixture composed of American cheese pasteurized, with added milk minerals. It is a good source of Vitamins A and G. Its protein is practically complete for building firm flesh. And Velveeta is digestible as milk itself!

Your Kraft distributor can supply Velveeta in convenient half-pound packages.

The World's Finest Cheeses are made or imported by **KRAFT**

FREE Monthly Service for dietitians

Valuable economical recipes for patients and staff!
Address: Kraft-Phenix Cuisine Service,
401-k Rush St., Chicago

Name.....

Hospital.....

City.....

For patients
with delicate digestion
HORLICK'S
MALTED MILK

How the unique Horlick Process makes Horlick's more Digestible

HORLICK'S, both from a scientific and practical standpoint, is an excellent food for the convalescent with impaired digestion. No raw milk is necessary in its preparation. Horlick's already contains safe, rich milk, modified with the soluble extracts of selected malted cereals and elaborated by the special Horlick process so that the casein of the milk is easily digested and avoids the formation of unduly large curds in the stomach.

Every ingredient in Horlick's is presented in an easily digestible form, hence it builds up the whole body in a most efficient manner. It furnishes a maximum of nutrition with the least tax upon the digestive organs. Keep your patients happy, as well as amply nourished, with Horlick's, the Original Malted Milk.

Convalescents do not tire of Horlick's full, delicious flavor.

BE ON GUARD

Be sure to insist on Horlick's—there are many inferior imitations on the market. Many of these imitations contain little of value for convalescent persons. They are merely mechanical mixtures of raw cocoa, skim milk powder and inferior malt. Specify Horlick's, the Original, and be sure that your patients get the best. Horlick's quality insures results.

SEND FOR SPECIAL OFFER

HORLICK'S MALTED MILK CORP., MH-10-35
Racine, Wisconsin.

Please send full information concerning your special price to institutions and offer on Horlick's, natural and chocolate flavors, in 10 lb. and 25 lb. bulk tins.

Name.....*Title*.....

Address.....

City.....*State*.....

NEWS IN REVIEW . . . .

Enrollment at Administrators' Institute Is 113; All Sections of the Country Represented

The third annual institute for hospital administrators held at the University of Chicago from September 11 to 25 brought an enrollment of 113 hospital executives. The committee in charge of the institute was particularly pleased with the quality of the enrollment and the character of the work offered.

The morning sessions were devoted to lectures and seminars by outstanding hospital authorities. The afternoons were spent in clinics and demonstrations in Chicago hospitals. Each evening except Saturday and Sunday a round table conference was held under the direction of Dr. Malcolm T. MacEachern to discuss the material presented in the morning and afternoon.

The faculty of the institute included: Charles A. Lindquist, Sherman Hospital, Elgin, Ill.; Maurice Dubin, Mount Sinai Hospital, Chicago; C. Rufus Rorem, Julius Rosenwald Fund, Chicago; Dr. Charles F. Wilinsky, Beth Israel Hospital, Boston; Edna Foley, Visiting Nurse Association, Chicago; A. M. Simons, American Medical Association, Chicago; Dr. Christopher G. Parnall, Rochester General Hospital, Rochester, N. Y.; Mary Hicks Bachmeyer, Chicago; Dr. Donald Smelzer, Graduate Hospital of the University of Pennsylvania, Philadelphia; Ella Eck, University of Chicago Clinics; Asa S. Bacon, Presbyterian Hospital, Chicago; Ada Belle McCleery, Evanston Hospital, Evanston, Ill.; Dr. B. W. Black, Alameda County Institutions, Oakland, Calif.; Dean William H. Spencer, University of Chicago; Dr. Basil C. MacLean, Strong Memorial Hospital, Rochester, N. Y.; John A. McNamara, Cleveland Hospital Association, Cleveland; Perry Addleman, Chicago Hospital Council, Chicago.

The final banquet of the institute was held on Tuesday evening, September 24.

Those registered were as follows:

Van C. Adams, Kahler Corporation, Rochester, Minn.; Helen C. Anderson, Chicago; Mrs. Minnie May Anderson, East Side General Hospital, Detroit; Robert S. Anderson, Leahi Home, Honolulu.

Katherine Baumann, Eye and Ear Hospital, Pittsburgh; Gladys M. Bayne, Grasslands Hospital, Valhalla, N. Y.; Alberta Bell, Grace Hospital, Toronto, Ont.; Leonard B. Benson, Bethesda Hospital, St. Paul, Minn.; Richard B. Benson, Methodist Episcopal Hospital, Indianapolis; Rev. John Bingham, Catholic Charities of the Archiocese of New York, New York City; Amy E. Birge, Holyoke Hospital, Holyoke, Mass.; Marion V. Black, Ellen Fitzgerald Hospital, Monroe, N. C.; Dr. Otto I. Bloom, Peoples Hospital, New York City; Winifred Brainerd, Presbyterian Hospital, Chicago; Rev. John L. Brennan, Catholic Charities of the Archdiocese of New York, New York City; Dr. M. Hubert Bruce, Wheatley-Provident Hospital, Kansas City, Mo.; J. B. Buschemeyer, Louisville City Hospital, Louisville, Ky.

Dr. Ferdinand Chenik, Chenik Hospital, Detroit; H. Gladys Collins, Marion General Hospital, Marion, Ind.; Helen J. Colteryahn, Children's Convalescent Home, Cincinnati; Mildred Constantine, Peter Bent Brigham Hospital, Boston; Horace Cooper, Allentown State Hospital, Allentown, Pa.; Elsa K. Cosner, Children's Hospital, Boston; Frances L. Croskery, Milton Hospital, Milton, Mass.

Matilda J. Dennison, Bethesda Hospital, Crookston, Minn.; Grace L. DeVilbiss, Woodlawn Hospital, Chicago; Harry C. Dunham, Flower Hospital, Toledo, Ohio; Mrs. Harry Dunham, Flower Hospital, Toledo, Ohio.

David A. Endres, Youngstown Hospital, Youngstown, Ohio.

Edna Fitts, Leaksville Hospital, Leaksville, N. C.; Mrs. Gertrude Folendorf, Shriners' Hospital for Crippled Children, San Francisco; Gordon A. Friesen, Saskatoon City Hospital, Saskatoon, Sask.; Herbert G. Fritz, Conemaugh Valley Memorial Hospital, Johnstown, Pa.

Frank B. Gail, West Jersey Homeopathic Hospital, Camden, N. J.; Madeline S. Gibbs, Children's Hospital, Boston; Flossie Gamble, Meridian Sanitarium, Meridian, Miss.; Mrs. Dixie E. Gosrow, Stanford University Hospital, San Francisco; Agnes Gray, Clinic Hospital, Greensboro, N. C.; Ora A. Green, Carlisle Hospital, Carlisle, Pa.; Herman J. Grimmer, Jr., Worcester City Hospital, Worcester, Mass.

Lydia M. Haase, T. J. Samson Community Hospital, Glasgow, Ky.; Susan G. Holmes, Abbott Hospital, Minneapolis, Minn.; Wilkie Hughes, Ball Memorial Hospital, Muncie, Ind.; Cleo W. Hull, City Hospital of Akron, Akron, Ohio.

Millie A. Jacobson, Chicago; Lucile M. Jakes, Cass County Hospital, Logansport, Ind.; Mrs. Genevieve Jeffrey, Anglo-American Hospital, Havana; Everett W. Jones, Albany Hospital, Albany, N. Y.; Mrs. F. Alice McGrath Jones, Fenway Hospital, Boston; Frank H. Judson, Canonsburg General Hospital, Canonsburg, Pa.

Frances E. Kitchen, Douglass Hospital, Kansas City, Kans.

Felix Lamela, School of Tropical Medicine, San Juan, P. R.; Charlotte F. Landt, West Allis, Wis.; Mary Lawless, Nassau Hospital, Mineola, L. I., N. Y.; Mrs. Mildred Lenoir, Eugene, Ore.; Martha C. Lockman, Carlisle Hospital, Carlisle, Pa.

R. Louis Malloy, University Hospital, Minneapolis, Minn.; Fleta C. Martin, Moody Hospital, Dothan, Ala.; Florence Mayfield, John N. Norton Memorial Infirmary, Louisville, Ky.; Bertha McElderry, Citizens Hospital, Talladega, Ala.; Alvin McGary, Good Samaritan Hospital, Lexington, Ky.; Anna C. McKeague, Williamsport Hospital, Williamsport, Pa.; Catherine S. McLeod, McKinney City Hospital, McKinney, Texas; Lydia A. Miller, Asbury Hospital, Minneapolis, Minn.; Robert J. Moore, Ellis Hospital, Schenectady, N. Y.; Nellie E. Mumford, Louise G. Wallace Hospital, Lebanon, Mo.

Beulah R. Ness, York Hospital, York, Pa.; Helen T. Nivison, Griffin Hospital, Derby, Conn.

Mamie R. Odden, Worthington Clinic Hospital, Worthington, Minn.; Martha C. Oosten, Jasper County Hospital, Rensselaer, Ind.; Wesley H. Ott, Warren City Hospital, Warren, Ohio.

Betty J. Phillips, Provident Hospital and Free Dispensary, Baltimore; Denzel M. Pittman, Methodist Episcopal Hospital, Indianapolis; Charlotte M. Powell, Blythedale Hospital and Home, Valhalla, N. Y.; Enda D. Price, Emerson Hospital, Concord, Mass.; Clarence R. Pugh, Bottom's Baptist Orphanage, Monticello, Ark.

V. Daniel Revenaugh, Louisville City Hospital, Louisville, Ky.; William M. Rich, Lincoln Hospital, Durham, N. C.; Nell Robinson, East Liverpool City Hospital, East Liverpool, Ohio; Edna M. Rockefeller, Muskogee General Hospital, Muskogee, Okla.; Rafael Rodriguez-Molina, School of Tropical Medicine, San Juan, P. R.; Earl G. Rowley, Citizens General Hospital, New Kensington, Pa.

Marjorie E. Saunders, Milton Hospital, East Milton, Mass.; Robert C. Schenck, University Hospital, Minneapolis; Mrs. Gela H. Schulte, Riverside Hospital, Paducah, Ky.; William A. Scott, Passaic General Hospital, Passaic, N. J.; N. Gertrude Sharpe, Morton Hospital, Taunton, Mass.; Stanley L. Sims, Butterworth Hospital, Grand Rapids, Mich.; Mrs. Ed. R. Sizer, Jr., Fred Roberts Memorial Hospital, Corpus Christi, Texas; Mary E. Skeoch, St. Luke's Hospital, Marquette, Mich.; Ann Brown Smith, McKinney City Mospital, McKinney, Texas; Donalda N. Smith, Babies' and Children's Hospital, Cleveland; Marvin W. Sory, Nashville Protestant Hospital, Nashville, Tenn.; Esther M. Squire, Grinnell Community Hospital, Grinnell, Iowa; Chloe M. Stewart, Metropolis, Ill.; Rose Q. Strait, Glens Falls Hospital, Glens Falls, N. Y.; Margaret V. Stevens, Brooklyn, N. Y.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; Carolyn B. Sykes, Southside Community Hospital, Farmville, Va.

Alice R. Thompson, Crawford W. Long Memorial Hospital, Atlanta; Dr. Girard V. Thompson, Medical College of Virginia, Hospital Division, Richmond, Va.; Mrs. Jewell W. Thrasher, Frasier-Ellis Hospital, Dothan, Ala.

Frieda W. Uppendahl, Sterling Hospital, Sterling, Kans.

Mrs. Clara E. Van Gadder, Bethesda Hospital, Zanesville, Ohio; Mary Lucy Vaughn, R. F. Strickland & Son Memorial Hospital, Griffin, Ga.

Edith M. Walls, Allerton Hotel, Cleveland; Nellie E. Walsh, Department of Hospitals, New York City; Montez Wayne, Petersburg Hospital, Petersburg, Va.; Dr. George O. Whitecotton, Alameda County Hospital, Oakland, Calif.; Jimmie Williamson, Moody Hospital, Dothan, Ala.; Margaret O. Williamson, Montgomery Hospital, Norristown, Pa.; Ethel Wittberg, Children's Convalescent Home, Cincinnati; Mrs. Marguerite W. Wood, Municipal Hospital, Haverhill, Mass.; Huldah, Wyland, Robinwood Hospital, Toledo, Ohio.

Twin Cities Unite in Group Plan; Membership Is 5,000

Minneapolis has now joined forces with St. Paul, Minn., in organizing a group hospitalization plan. The new officers of the combined group, called the Minnesota Hospital Service Association, are: Dr. Peter D. Ward, Chas. T. Miller Hospital, St. Paul, president; Joseph J. Norby, Fairview Hospital, Minneapolis, vice-president; Thomas P. Wallace, president, Farmers-Mechanics Bank, Minneapolis, treasurer; Victor M. Anderson, Abbott Hospital, Minneapolis, assistant treasurer; A. M. Calvin, Midway & Mounds Park Hospitals, St. Paul, secretary; E. A. van Steenwyk, executive secretary.

The membership of the association is over five thousand and a monthly increase of approximately one thousand is expected.

Radio broadcasting stations from St. Paul and Minneapolis have offered the use of their stations for thirty-six broadcasts during the next few months. Hospitals included in the plan are as follows: Abbott, Asbury, Deaconess, Eitel, Fairview, Northwestern, St. Andrew's, St. Barnabas, Swedish, all of Minneapolis; Bethesda, Midway, Chas. T. Miller, Mounds Park, St. John's, St. Luke's, West Side General, all of St. Paul.

ELI LILLY AND COMPANY

FOUNDED *1876*

Makers of Medicinal Products

Entoral is a mixed respiratory vaccine for oral administration. Clinical experience thus far indicates that colds are reduced 40 to 60 percent in the vaccinated subject. Entoral is of high heterophile antigen content. Entoral employs a new immunizing principle offering, in addition, a convenient method of administering the dose in capsule form.

Prompt Attention Given to Professional Inquiries

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

Successful Year Reported for English Group Plan

With nearly 290,000 contributors and total receipts of over $800,000 the Merseyside Hospitals Council (Liverpool, England) states in its recent annual report that 1934 was the most successful year in its history. The income was over $80,000 larger than in the previous year.

This large group hospitalization plan, of which Sydney Lamb is secretary and executive officer, provides not only hospital care in voluntary hospitals but also care in municipal hospitals when needed, ambulance service, convalescent treatment and home nursing care. The funds are distributed to the hospitals in accordance with their needs as well as with the services they render to contributors.

A fleet of five ambulances is maintained by the council, the most recently acquired ambulance being a gift of Viscount Wakefield of Hythe. In addition to the ambulance service there is a volunteer motor service at night, the entire expenses of which are met by the volunteer committee in charge.

"The council has for many years," states the report, "desired to establish a contributory scheme for persons of limited means, but was unable to make arrangements with the medical profession. During 1934 the hospitals made an agreement with the medical profession under the auspices of a new body, the Hospital Service Association of Merseyside. This body operates independently of the council."

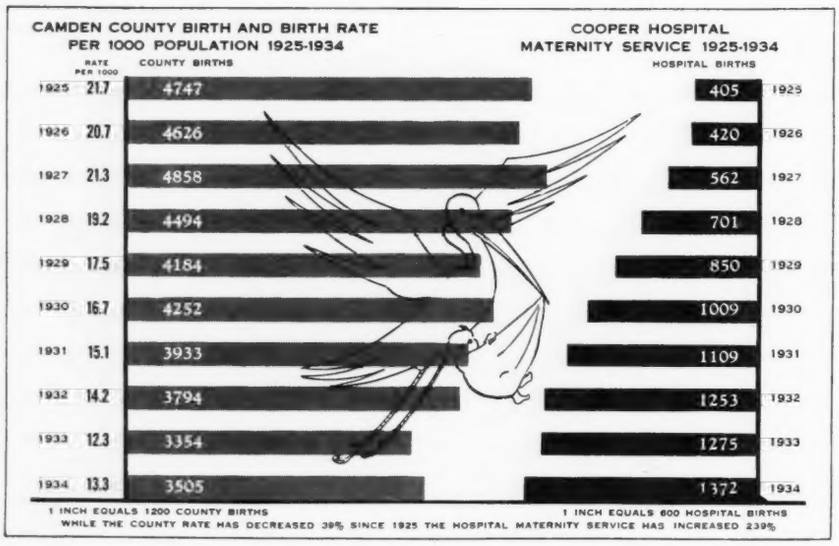
Lord Cozens-Hardy, chairman of the council, states that the council willingly gave consent to Mr. Lamb to accept the invitation of the American Hospital Association to address their thirty-sixth convention in Philadelphia last year.

While the report calls the contributory scheme the rebuilding of a new structure of hospital maintenance on the old foundations of the voluntary system, it points out that the present rate of contribution, namely, one penny in each pound or fraction of weekly income, is insufficient to maintain the present services carried on by the council. An extra penny a week from each contributor would go far towards putting the contributory fund on a sound actuarial basis, it is stated.

Irish Sweepstakes Aids Hospital

Grateful appreciation to the people in the United States and in other countries for their support of the Irish Hospital Sweepstakes is expressed in the 1934 annual report of Teac Ultain, the children's hospital in Dublin, Ireland. "This year an x-ray plant has been added for which thanks are due not alone to our friends in the U. S. A., but to those all over the world who purchased tickets in the Irish Hospitals Sweep," the report says. "We are indebted also to the Sweeps for aid in clearing the site of the new hospital." This fifty-two-bed hospital for children under two years of age had an average daily occupancy during the year of 51.4, practically all of them free or part-pay patients. Total expenditures were approximately £5,000, of which only 10 per cent was paid by patients.

Hospital Work Portrayed in Annual Report



Interesting, distinctive and attractive as usual is the forty-seventh annual report of Cooper Hospital, Camden, New Jersey, which was recently published. Through the generous use of pictures and charts such as the one shown above the most significant aspects of the hospital's work are graphically portrayed.

Specialty Courses for Nurse Graduates Announced

Postgraduate courses now available for registered nurses at the New York Post-Graduate Hospital, New York City, are a six-months' course in operating room technique and a nine-months' course in pediatric nursing. These courses are announced for fall registration to graduates of accredited schools of nursing.

Nathalie Borg will be the instructor in operating room technique and management. She was formerly supervisor of operating rooms at the Homeopathic Hospital, Washington, D. C., and for several years was assistant supervisor of operating rooms at the New York Post-Graduate Medical School and Hospital. Ellen Dever has been appointed instructor in pediatric nursing. She is a graduate of Children's Hospital, Boston, and of Teachers' College, Columbia University.

Other courses to be added in the immediate future are the administration and supervision of out-patient departments and administration and supervision of hospital wards.

This development at the hospital parallels the postgraduate teaching of physicians which has been the special field of this institution since its founding in 1882.

Will Continue as Bulletin

The board of councilors of the Association of Western Hospitals at a recent meeting voted to continue the magazine *Western Hospital Review* as an association bulletin, limiting its editorial content to news items, reports of association activities and information on projects of interest to Western hospitals. The publication has in recent years been a general hospital magazine sponsored by the Association of Western Hospitals.

A. M. A. to Broadcast

Each Tuesday, beginning October 1, at 5 p.m. Eastern Standard Time (4 p.m. Central Standard Time, 3 p.m. Mountain Time) the American Medical Association will broadcast a radio dramatic program over NBC on the subject of "Medical Emergencies and How They Are Met."

Hospital Stays Shorten

Although the number of persons admitted to nonmunicipal hospitals in New York City increased from 437,995 in 1933 to 455,724 in 1934, the average length of stay for each patient dropped from 15.1 to 14.4 days, according to statistics recently made public by the United Hospital Fund Information and Service Bureau.

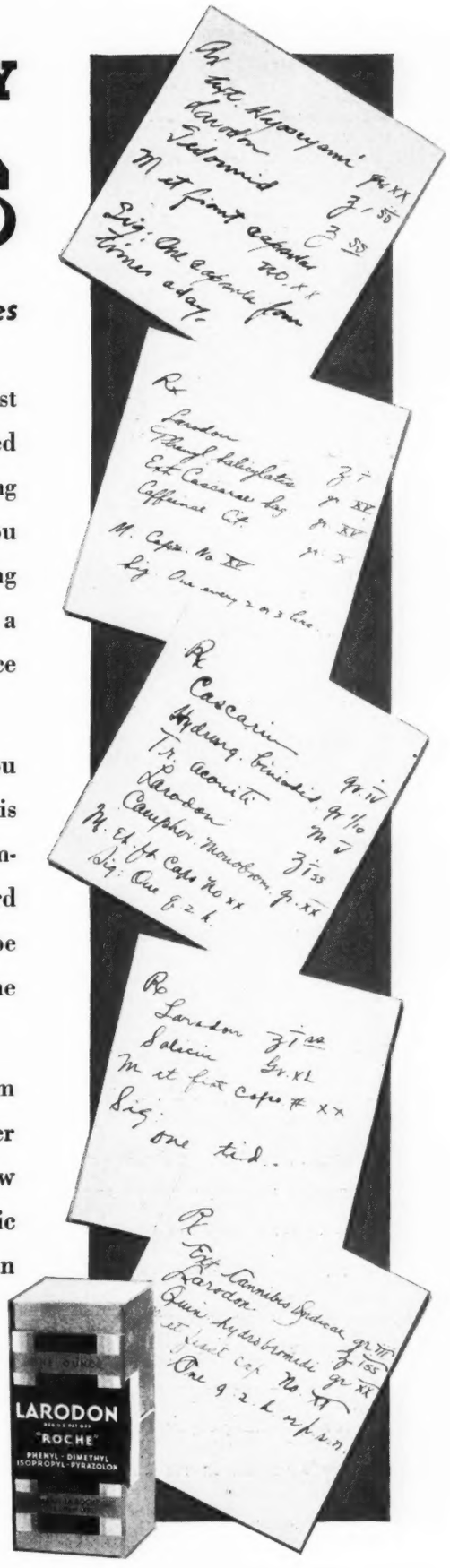
CAN YOUR PHARMACY FILL THESE Rx'S

The answer depends directly on hospital policies

Show the prescriptions in the panel to your hospital pharmacist and ask the question. If your policy is to encourage unhampered selection of medication for each individual patient according to the therapeutic judgment of the attending physician, if you regard your pharmacy department as a vital means of keeping the quality of medical care elevated to the highest plane, yet a division which takes less than 3% of your total maintenance cost to operate, the answer will be "Yes".

You couldn't want it to be "No", for it would mean that you stint your drug department in appropriations, that economy is overplayed to the extent that physicians are constantly complaining that they can't get new inexpensive remedies for ward patients, that some items for which private patients would be charged anyway aren't in stock, but have to be sent for, to the inconvenience of all concerned.

More and more hospitals are operating their pharmacies from the viewpoint of service. They have found that they get better co-operation of and with the medical staff when physicians know without asking that an important new analgesic and antipyretic like Larodon 'Roche' will be stocked just as soon as it is put on the market. The hospital pharmacist who is able to do such things enjoys the confidence of the medical staff, who in turn are ready to co-operate with him on other problems.



Larodon is available in 5-grain tablets and in powder. Write our Hospital Department for special direct-to-hospital prices and file of latest Roche descriptive literature. *Professional samples on request.*

HOFFMANN-LA ROCHE, Inc., Nutley, N. J.

NEW BUILDING PROJECTS

VICTORIA, B. C. — A gift of $2,500 for the purchase of radium has been received by the Provincial Royal Jubilee Hospital from Mrs. Sayward-Wilson.

ATLANTA, GA. — The WPA has appropriated funds for construction work at Grady Hospital as follows: to complete construction on two new units, including an addition to the colored out-patient department, doubling the department's capacity — $28,000; to build a new concrete service tunnel to contain all steam lines, hot water lines and gas lines, each building to be attached to these various services at the most convenient location—$30,000; to recondition an unused building on the grounds for use as a colored nurses' home, to be connected with the present colored nurses' home which is inadequate for the hospital's needs — $100,000; to remodel the central kitchen, dining rooms, storeroom, drug room, and for sundry other improvements — $30,000.

WARSAW, IND. — Work will be started early this fall on a new twenty-five-bed hospital to be built by Dr. J. R. Baum. The plans have been drawn by A. M. Strauss, architect, Fort Wayne. The building will have two stories and a basement and will be of light colored, face brick.

KNOXVILLE, IOWA. — The Veterans Administration Facility has been allotted $725,000 to provide 300 beds and a new boiler plant. The money is part of the $20,000,000 provided in the second deficiency bill for improvements to veterans administration hospital facilities.

ANN ARBOR, MICH. — An arthritis clinic was recently organized at the University of Michigan Hospital. Patients may be referred to this clinic for consultation.

WALKER, MINN. — The new $250,000 Indian tuberculosis hospital constructed by the federal government adjacent to the state hospital has been opened for patients.

RIVERSIDE, N. J. — The new Zurbrugg Hospital, with a capacity of forty beds, was opened recently after a delay of three years. The hospital was built with funds left by Theophilus J. Zurbrugg but no money was available for operating expenses until the Burlington County board of freeholders agreed to aid in its maintenance.

CANANDAIGUA, N. Y. — Recent federal allotments call for the expenditure of $1,200,000 for the construction of additions to the U. S. Veterans' Hospital. Four new buildings will be constructed, increasing the bed capacity from 500 to about 1,200.

NORTHPORT, LONG ISLAND, N. Y. — Six additional buildings enlarging the capacity of the Veterans Administration Facility by 800 beds are planned by the Veterans Administration Bureau, acting on the authority of a recent law appropriating $1,500,000. The new buildings will provide more wards, a warehouse, laundry, dining rooms and recreation halls.

RALEIGH, N. C. — A new home for Rex Hospital is under way and construction will begin soon on the building, which is a PWA $387,000 project. The site is on the crest of a hill and the hospital will be surrounded by landscaped terraces and gardens. The building will rise four stories in front and six stories in the rear, because of the slope of the hill. It will be of red brick with stone cornices and iron parapet railings.

SALISBURY, N. C. — A new building is being planned for the Rowen General Hospital. The building committee has announced that funds are available for the erection of the building which will be of brick and granite, four stories high and of eighty-bed capacity. The Duke Endowment has contributed part of the money and the rest has been donated. An additional campaign for $20,000 will be necessary to provide equipment.

LONDON, ONT. — A bequest of approximately $18,000 is to be divided equally between Victoria Hospital and the Queen Alexandra Sanatorium, being the residue of the estate of William Urquhart, Thamesford, which was left to the two institutions.

COATESVILLE, PA. — A new 315-bed structure will be erected at a cost of $600,000 for the Veterans Administration Facility.

NORRISTOWN, PA. — Application is to be made for PWA funds for the construction of a number of new buildings at the Norristown State Hospital.

SPANGLER, PA. — Construction of a $134,000 wing to Miners' Hospital of Northern Cambria, has been authorized by the board of trustees. Application will be made for a PWA loan to carry on the work. If a loan and grant are secured through the PWA, 90 per cent of the workmen must be drawn from relief rolls, federal regulations provide.

PUERTO RICO. — The construction of four district hospitals to care for the sick of the island has been authorized by Governor Blanton Winship. The construction of these hospitals is to be financed by a half million dollar loan. They will be maintained through special appropriations made from the yearly insular budget.

COLUMBIA, S. C. — Plans for the development of the South Carolina Baptist Hospital to an ultimate capacity of 215 beds were adopted at a recent meeting of the hospital's board of trustees. The program includes the erection of a new hospital building to provide sixty-six beds, at an estimated cost of $105,000, and the purchase of new equipment and furnishings at an estimated cost of $25,000.

SOUTH CAROLINA. — Two South Carolina counties plan twenty-bed hospitals in the near future, construction costs to be defrayed from bond issues and from WPA funds. The Jasper County hospital will be erected at Ridgeland at a cost of $41,500, of which $15,000 was obtained from a county bond issue. Barnwell County hospital will be built at Barnwell and will cost approximately $40,000. F. Arthur Hazard, Augusta, is the architect.

MEMPHIS, TENN. — Work on the half-million dollar improvement to the Marine Hospital will begin shortly. In addition to $500,000 for construction, $144,000 will be allowed for administrative expenses.

SAN ANTONIO, TEX. — Contract for the construction of the new Fort Sam Houston Hospital has been let for $1,347,400 and construction will begin as soon as work on the foundation, now more than two-thirds complete, is finished.

OGDEN, UTAH. — Thomas D. Dee Memorial Hospital recently awarded a contract for the construction of a new unit to include administrative offices and additional bed accommodations. Provision is made for thirty beds, bringing the hospital's capacity to approximately 225 patients. The plans call for an expenditure of approximately $100,000.

SALT LAKE CITY, UTAH.—St. Mark's Hospital recently completed construction of a pediatric department with a capacity of seven beds. The hospital has also provided a special department to take care of all cases involving the eye.

CLARKSBURG, W. VA. — Extensive improvements, including a new wing and new heating and laundry plant at the rear of the present building, are to be constructed soon at St. Mary's Hospital. L. D. Schmidt, Fairmont, has been engaged to draw plans for the additions.

MILWAUKEE, WIS. — A site is being sought near here for a new mental hospital for veterans for which $944,000 has been authorized. The government wants 300 acres of land to be donated by some local government as a site. Money for this project, as well as a $350,000 general hospital for veterans to be located in Milwaukee, is provided in the second deficiency bill for improvements to Veterans Administration hospital facilities.

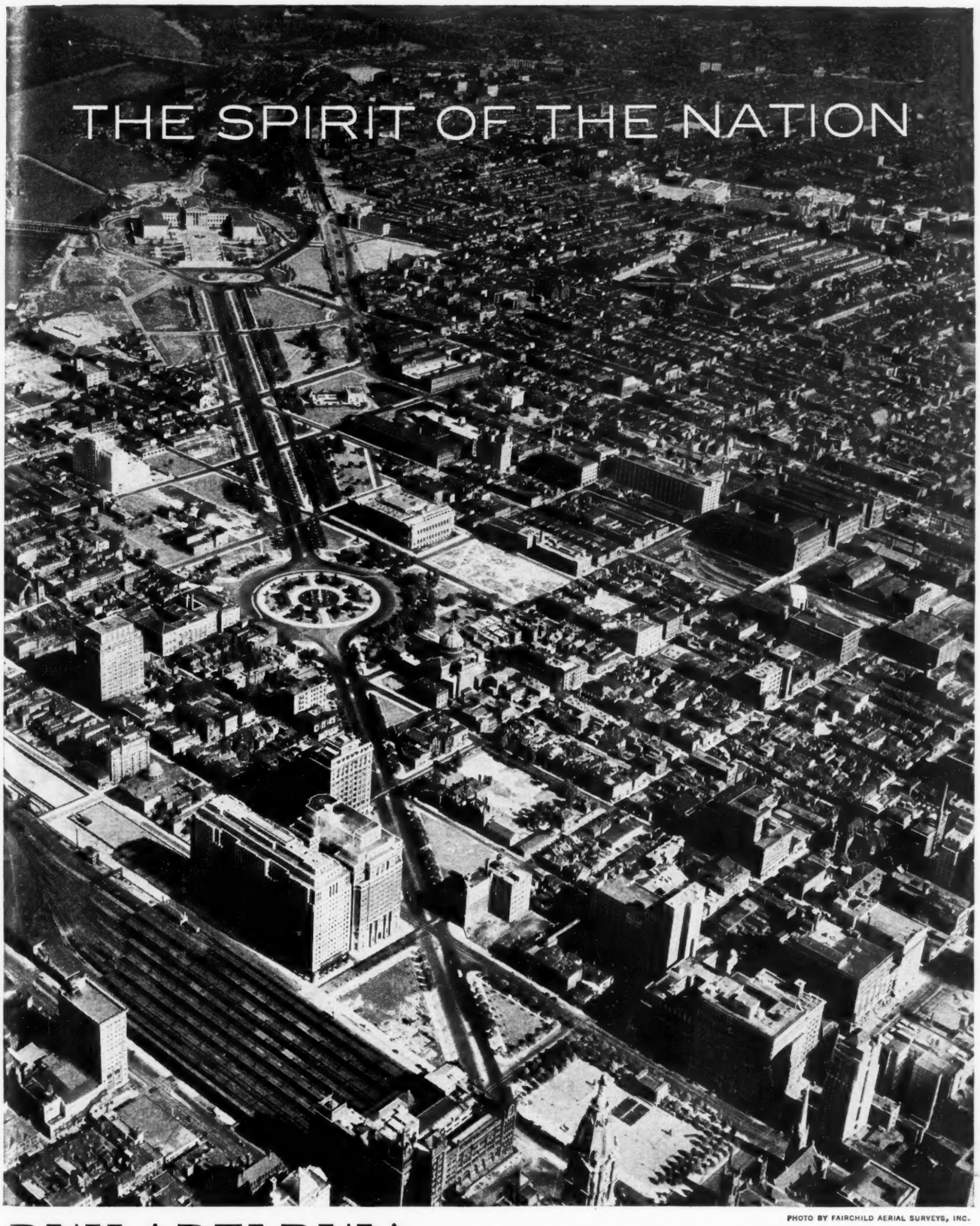


PHOTO BY FAIRCHILD AERIAL SURVEYS, INC.

PHILADELPHIA . . "The world's workshop." An industrial giant demanding large quantities of ROSSVILLE ALCOHOLS . . . for every industrial, scientific, and pharmaceutical purpose. Quick delivery of ROSSVILLE ALCOHOLS to Philadelphia's trading territory is made possible through central warehouse facilities.

COMMERCIAL SOLVENTS CORPORATION

NEW YORK CENTRAL BLDG., NEW YORK, N.Y.

ROSSVILLE ALCOHOL . . THE SPIRIT OF THE NATION

Three Nursing Organizations to Hold Institute

The Minnesota State Nurses Association, the Minnesota Organization for Public Health Nursing, and the Minnesota State League of Nursing Education are sponsoring an institute for the study of psychiatric principles, to be held October 21 to 25, inclusive, at Fergus Falls State Hospital, Fergus Falls.

The aim is a general orientation in psychiatric problems through a course of lectures, clinical demonstrations and conferences.

This first institute is designed for nursing executives or representatives selected by the directors from the executive group of their respective institutions. At a later date, other institutes will be held enrolling other groups of nurses.

The lectures will be given by Dr. W. L. Patterson, and Dr. M. W. Kemp, superintendent and assistant superintendent, Fergus Falls State Hospital. They will be assisted with the clinics by the members of the medical staff. The nursing care will be outlined by Mrs. Stella H. Amass, director of psychiatric nursing education. The demonstrations will be given by the special therapists.

Chicago Hospital Council Outlines Early Plans

The Chicago Hospital Council, which is in process of organization, as reported in the August issue, has outlined three specific problems on which it proposes to concentrate attention immediately. Practically all of the approved hospitals of Chicago have been invited to consider this program of work and to join the council.

Under "public relations" a bulletin issued by the temporary organization committee states that "the council will undertake to plan, organize and carry out a complete publicity and public relations program" which will inform and educate the public regarding the situation and services of hospitals, the intelligent use of hospital services and the value and cost of independent hospital services. Special attention will apparently be given in the publicity to plans of the council for amplifying services and obtaining better and fuller use of hospital plants in order to decrease hospital costs.

The second function outlined for immediate attention involves research and studies of group hospitalization, of hospital needs and services, of interrelations among hospitals and between hospitals and government agencies and of methods for bringing the cost of hospital care within the reach of all persons.

The third activity is the development of plans and organization for carrying into effect the conclusions reached in the research and studies. "The purpose of such plans," states the bulletin, "should be to decrease overhead costs by increasing use of capital facilities." Other subjects mentioned are the reorganization of services to meet new needs, centralization and exchange of information on operating experience, and administration of all extra-hospital activities which can be handled centrally.

The bulletin states that membership in the council will, it is assumed, be on an institutional basis with the superintendent, a board member and a staff member for each hospital. It is also contemplated that various national and local agencies will be represented. The bulletin was issued by the temporary organization committee of which Charles H. Schweppe, president of St. Lukes Hospital, is chairman and Perry Addleman is executive director.

Doctor Baxter, Founder of Baxter Laboratories, Dies

The recent death of Dr. Donald E. Baxter at Leaburg, Ore., removes a man who had long been active in hospital affairs. From 1912 to 1914 he was assistant superintendent of the Minneapolis General Hospital. He resigned from there to become the eastern editorial representative of THE MODERN HOSPITAL.

After the epidemic of infantile paralysis, a committee was organized in New York to provide after care for the many cripples. It drafted Doctor Baxter to organize its work. This was done so effectively that the Rockefeller Foundation selected him to participate in its program for the care of civilian tuberculous patients in France. Later the foundation called him to assume administrative responsibility in connection with the Peiping Union Medical College.

In 1921 he engaged in private medical practice in Glendale, Calif. Later he established the Baxter Laboratories for the manufacture of standardized intravenous solutions. Doctor Baxter was a fellow of the American Medical Association, a member of the American Hospital Association and of many other professional organizations. He is the author of "After Care of Infantile Paralysis," "Chemistry and Manufacture of Anesthetics" and other medical books.

Campaign Is Successful

A campaign for $75,000 for Wesson Maternity Hospital, Springfield, Mass., was conducted recently to "enable the hospital to carry the increasing load of charity work now required of it," as stated by Stephen S. Taft, president of the hospital.

BEQUESTS AND GIFTS

ILLINOIS. — A trust fund of more than $2,000,000 will be available to the University of Chicago for the establishment of a free dental dispensary and clinic according to the provisions of the will of the late W. G. Zoller, former vice president of the Bell & Zoller Coal Company. It is expected that the work on this project will start within the next few months.

WISCONSIN. — Columbia Hospital, Milwaukee, has received a bequest of $7,000 from the estate of the late Mrs. Sarah A. Spalding to finance a new department for treatment of cancer by high voltage roentgen therapy. Two rooms have been set aside for the new department, in which a high voltage x-ray machine is to be installed. Dr. Silvanus A. Morton will be in charge.

Coming Meetings

American Public Health Association.
President, Dr. Eugene L. Bishop, Nashville, Tenn.
Executive secretary, Dr. Reginald M. Atwater, 50 West Fiftieth Street, New York City.
Next meeting, Milwaukee, Oct. 7-10.

Ontario Hospital Association.
President, Brig. Gen. C. M. Nelles, C. M. G., Niagara-on-the-Lake
Secretary-treasurer, Dr. Fred W. Routley, Maple.
Next meeting, Toronto, Oct. 15-17.

Kansas Hospital Association.
President, Rev. John E. Landers, Wesley Hospital, Wichita.
Secretary, Dr. John T. Axtell, Axtell Christian Hospital, Newton.
Next meeting, Emporia, Oct. 26.

American Dietetic Association.
President, Laura Comstock, Rochester, N. Y.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Cleveland, Oct. 28-31.

American College of Surgeons.
President, Dr. Robert B. Greenough, Boston.
Director-general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, San Francisco, Oct. 28-Nov. 1.

Association of Record Librarians of North America.
President, Edna K. Huffman, St. Joseph's Hospital, Chicago.
Corresponding secretary, Helen Hays, St. Alexis Hospital, Cleveland.
Next meeting, San Francisco, Oct. 28.

Colorado Hospital Association.
President, Dr. John Andres, Longmont Hospital, Longmont.
Executive secretary, Wm. S. McNary, University of Colorado Hospital, Denver.
Next meeting, Denver, Nov. 5-6.

Alberta Hospital Association.
President, S. H. Adams, Calgary.
Secretary-treasurer, James Rodgers, Municipal Hospital, Drumheller.
Next meeting, November.

Hospital Association of New York State.
President, James U. Norris, Woman's Hospital, New York City.
Executive secretary, Carl P. Wright, General Hospital of Syracuse.
Next meeting, Buffalo, May 21-22, 1936.

Resilience...the secret of these RESTFUL FLOORS

IN a hospital floor, resilience means everything. It means rest for nurses, doctors, and technicians who must be on their feet all day long. It means quiet and comfort underfoot. It means consideration for convalescents who find walking a task.

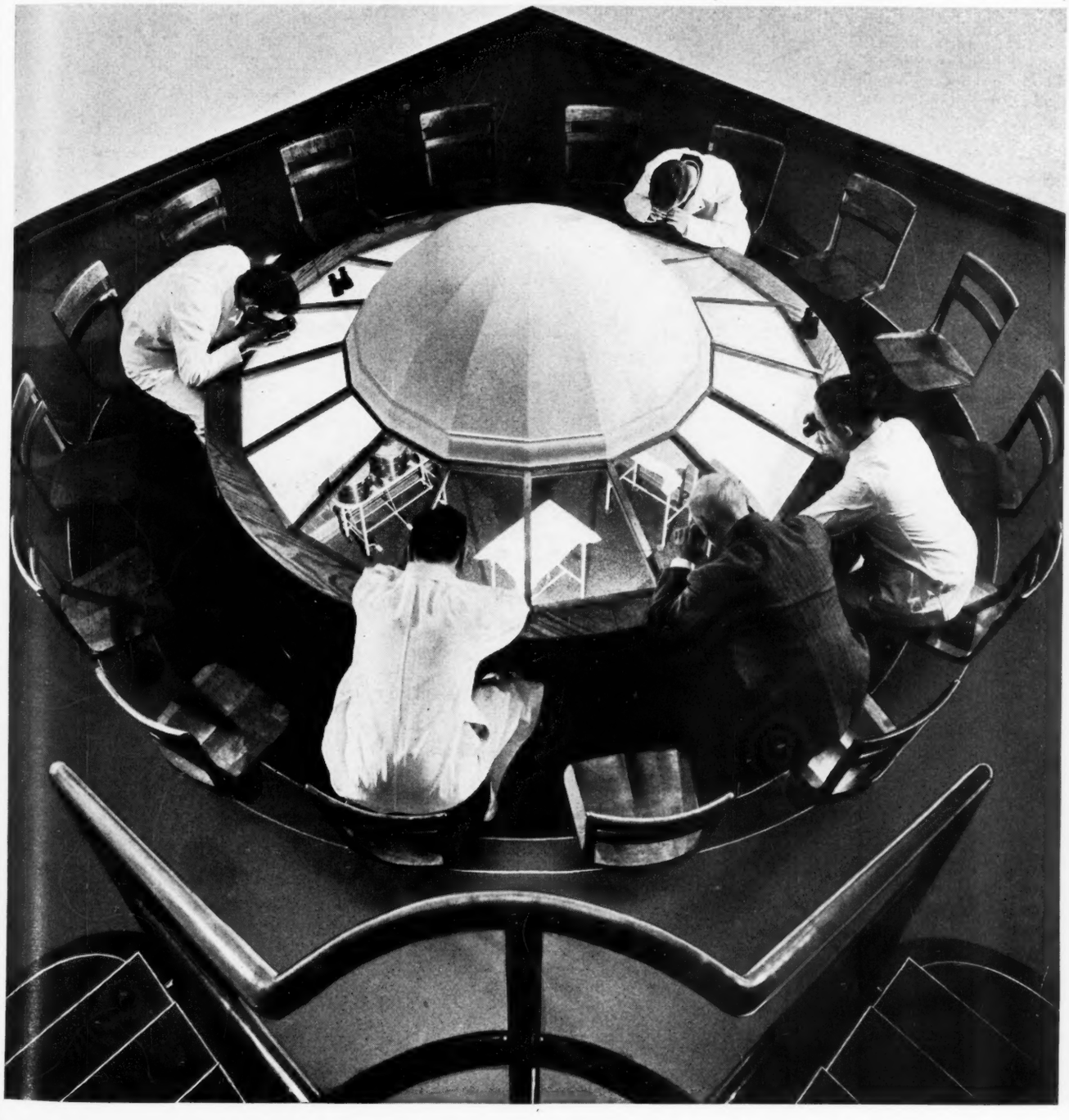
An Armstrong's Linoleum Floor is resilient, but it is much more than that. It is colorful, and color is coming into its own as a therapeutic agent.

It is easy and economical to maintain in a sanitary condition, because it does not crack or grow rough, leaving places for germs to breed. And when waxed with Armstrong's Linogloss Wax (no rubbing), it is bright but not slippery. That's why you'll find Armstrong's Linoleum Floors in many of the largest and best-managed hospitals, as well as in the private offices of physicians.

Write now for "Public Floors of Enduring Beauty." Armstrong Cork Products Co., Building Materials Division, 1210 State Street, Lancaster, Penna.

Armstrong's LINOLEUM FLOORS

In this observation gallery at Columbia-Presbyterian Medical Center, New York, and in other rooms, are 4000 sq. ft. of Armstrong's Linoleum in nine plain colors.



Communicable Disease Facts Published in Report

A noteworthy compilation of available information and medical opinion on the control of communicable diseases is contained in a report of the American Public Health Association recently published by the U. S. Public Health Service. The committee was under the chairmanship of Dr. Haven Emerson, College of Physicians and Surgeons, New York City.

Sixty-two different diseases are included, divided into three groups: first, communicable diseases for which notification is usually required; second, communicable diseases or infestations for which notification is not everywhere required, and, third, diseases of concern to health officers and sometimes made notifiable but not to be considered communicable in the usual sense of the term.

Each disease is briefly described with regard to its clinical and laboratory recognition, the etiologic agent, the source of infection, the mode of transmission, the incubation period, the period of communicability, susceptibility and immunity, and prevalence. Following this are offered methods of control—first, those affecting the individual, contacts and immediate environment, and second, general and specific measures bearing upon the control or prevention of the disease in question.

Sections of the report that will be of special interest to hospital administrators include those on food infections and poisonings, impetigo, ringworm, whooping cough, tuberculosis, syphilis, poliomyelitis, acute lobar pneumonia, mumps, measles, malaria, influenza, gonorrhea, dysentery, chicken pox and conjunctivitis.

Copies of the report may be obtained from the superintendent of documents, Washington, D. C., or the U. S. Public Health Service.

A. N. A. Publishes Booklet on Nursing Situation

To facilitate quick reference, the American Nurses Association has published a handbook for speakers and others entitled "Some Facts About Nursing." This book brings together from many sources data about the present nursing situation. It was prepared under the direction of Mary M. Roberts by the Nursing Information Bureau of the association.

Among the interesting facts listed in the book are some concerning deficiencies of nurses. "We have a great need of nurses with training better than that which is given by the typical hospital school. We need trained nurses with a broader experience and better basic professional background. We need more really skillful professionally-minded bedside nurses. We need nurses who have taken specialized training following the R.N. to fit them for special responsibilities."

The most serious weaknesses in schools of nursing are given as too few good teachers, too few workers, insufficient time and not enough emphasis on what good nursing really is.

Typical (that is, median) salaries for institutional nurses in 1935 are given as follows: superintendent of hospital $3,600; superintendent of hospital and nursing service, $1,885; superintendent of nurses, $2,040; assistant superintendent of nurses, $1,360; night superintendent or supervisor, $1,140; day supervisor (in charge of two or more wards), $1,120; instructor, $1,350; operating room supervisor, $1,200; head nurse, $1,000; assistant head nurse, $840, and general floor duty nurse, $720. The study revealed that salaries for all types of positions in the professional group increase proportionately with the size of the hospital. All of the salaries are in addition to full maintenance.

The book is replete with similar facts and data.

Catholic Hospital and Nursing Groups Meet in Chicago

Strong objection to the practice of moving Catholic Sisters from one position to another was voiced by Dr. Austin A. Hayden of the staff of St. Joseph's Hospital, Chicago, addressing the fourteenth annual meeting of the Illinois Conference of the Catholic Hospital Association in Chicago on September 17.

"When a Sister becomes experienced and skillful in her work she ought not to be moved on to another position to be replaced by another Sister," Doctor Hayden stated. He said that he made this statement in spite of the fact that he was well aware of the reasons for such rotation.

The advantages of a centralized purchasing department in each hospital were listed by Sister Christiniana, St. Mary's Hospital, East St. Louis. They are, she said, better price and quality (provided the purchasing agent consults with the department heads), less overstocking, more uniformity in the use of supplies, and purchasing at the right time in the market fluctuation. Sister Christiniana emphasized that economy should never sacrifice quality or, in food particularly, a good variety.

The steps being taken by the Association of Record Librarians of North America to advance the training and value of record librarians were outlined by Mrs. Edna K. Huffman, president of the association and record librarian at St. Joseph's Hospital, Chicago.

One hundred sixty-one Sisters registered at the conference and the total attendance was over 200.

Following the hospital meeting the National Conference on Nursing Catholic Action convened in Chicago for a three-day session on September 19 to 22. An interesting feature of the program was a panel discussion of the various nursing organizations as viewed by student nurses. On Sunday holy mass and communion were held by Rev. John W. Barrett, diocesan director of Catholic hospitals in Chicago. Rev. Mr. Barrett also presided at the meeting of the hospital association.

Doctors and Nurses Honor Doctor Trudeau

At the annual meetings of the American Sanatorium Association and the National Tuberculosis Association, held recently at Saranac Lake, N. Y., the memory of Dr. Edward Livingston Trudeau, often called the father of the sanatorium movement in America, was honored by hundreds of physicians, nurses and laymen representing 2,000 tuberculosis associations and 600 sanatoriums in the United States.

Doctor Trudeau, afflicted with tuberculosis, cured himself at Saranac Lake fifty years ago. He opened the now famous "Little Red Cottage" in 1885 to extend to others the rest cure with which he had cured himself.

At the meeting the "Cottage" was dedicated and a bronze plate mounted upon it was unveiled.

Course Offered for Librarians

A new training course for record librarians has been announced by St. Joseph's Hospital, Chicago. The course, which will open next January, will be designed to meet the minimum requirements of the Association of Record Librarians of North America and will be under the direction of Mrs. Edna K. Huffman, who is president of the association. Four students will be accepted each year for a one-year course. For the first year the students will be all well trained people — two Wellesley graduates, a graduate nurse, and a Catholic sister with both B.S. and R.N. degrees.

Jerusalem Hospital Fund Gains

The building fund for the Rothschild-Hadassah-University Hospital, to be built in Jerusalem by the Women's Zionist Organization of America and the American Jewish Physicians Committee, totals $106,000, it was announced recently by Mrs. Moses P. Epstein, acting president of Hadassah. Preliminary architectural plans are being completed in Palestine.

Armored at the wrist, the new Matex dermatized gloves protect against glove failure by placing *extra-strength* at the most vulnerable spot. To the surgeon, this means practically an elimination of wrist-tearing, when pulling the glove on the hand. To the hospital it assures greater economies as measured in actual dollars.

This cut-away cross section view illustrates how the Armored Wrist Glove appears under magnification. Ask your Matex dealer to show you samples.

The MASSILLON
RUBBER COMPANY
MASSILLON - - OHIO

ALL SURGEONS

TRADE MARK

Have pride in their skill. They must, however, rely upon their instruments to obtain perfect results.

To guarantee safety they cannot be indifferent to their origin. A small saving in cost is false economy in surgical instruments.

Kny-Scheerer instruments may cost more but you get forty-six years of devotion to quality.

Select surgical instruments that are known for quality, to match your skill and your desire to serve.

SEE THAT YOU GET THE MAKE OF INSTRUMENTS THAT YOU SPECIFY

Precaution may save disappointment and regret. All recognized surgical dealers can supply you with Kny-Scheerer surgical instruments. Apply to your surgical dealer for our new DeLuxe catalog.

KNY-SCHEERER CORPORATION
[THE QUALITY HOUSE]
21-09 BORDEN AVENUE LONG ISLAND CITY, N. Y.

New Isolation Pavilion Opened at Gallinger Hospital

The new contagious disease building of Gallinger Municipal Hospital, Washington, D. C., was dedicated September 3 and was formally occupied by patients the following morning. Dr. Hugh S. Cumming, surgeon general, U. S. Public Health Service, was the principal speaker at the dedication ceremonies.

This isolation pavilion is planned in the form of a Y and has, roughly, four subdivisions for the care of (1) measles, (2) diphtheria, (3) scarlet fever, (4) miscellaneous conditions. These divisions are further subdivided into small wards with cubicles, semi-private compartments and separate rooms. Each compartment is equipped with a shower, a toilet, a hand basin and other facilities, making it complete in itself. Individual kitchens, laundry service and nursing outlays are provided for each of the four main subdivisions.

The capacity of the building is 156 beds. Four sun parlors on the ends of each annex are so planned that two beds may be placed in each, somewhat raising the normal capacity of the building when necessary. Entirely new and modern equipment has been provided throughout.

Name Is Changed

The name of the San Diego Hospital, San Diego, Calif., has been changed to Hoffman Memorial Hospital, to perpetuate the name of the man in whose honor the hospital was originally dedicated.

Queens General Hospital Now Practically Complete

Arrangements for the opening of the Queens General Hospital, Jamaica, N. Y., are now practically completed, the department of hospitals of New York City has announced. Bids for x-ray equipment were opened on September 12. The contract for this equipment contains a sixty-day delivery clause. The opening of the hospital will be preceded by formal dedication exercises, which will be held, subject to Mayor LaGuardia's approval, on October 30. During the remainder of the week the hospital will be open to public inspection.

Actual service at the new hospital will be built up step by step, according to a prearranged plan. Members of the visiting staff assigned to service in the out-patient department are being instructed to report for duty on Wednesday, November 6. The first ward patient will be admitted on or about November 18. The hospital will be able to accommodate nearly 600 without overcrowding. Three ambulances will be assigned to it.

The medical superintendent in charge, Dr. Marcus D. Kogel, has been connected with the Department of Hospitals since 1927, and before receiving his present assignment was medical superintendent of Cumberland Hospital.

The cost of the plant was $3,845,000. The opening of the hospital, long delayed on account of lack of municipal funds, became possible when PWA grants for the completion of the building and its equipment were made, totaling $800,000.

First Number of Hospital Bimonthly Appears

Journalistic enterprise of a high order is displayed in the new bimonthly publication of the University Hospitals of Cleveland. Under the name of the *University Hospitals Illustrated News*, the first issue was published in September.

A four-page paper, 12 by 16 inches, its appeal is to all classes of patients and the public. For those who read English with difficulty, the hospital's story is told in large pictures. The front and back pages are entirely pictorial in nature, with interesting captions narrating the story.

The inside pages, too, are generously illustrated, and the editorial text concerns up-to-the-minute news. On the editorial advisory board are the board of trustees, the directors of the various services and the administrative heads. Each department has its own correspondent, from the multigraphing room and telephone service to the x-ray department.

Illustrations are large, clear and detailed, owing to the fact that the publication is printed on magazine stock. Among the featured news is the reopening of Babies and Childrens Hospital after two years. A front page pictorial strip with captions tells the story of Joe Krchmar, the first patient to undergo Dr. Claude S. Beck's new operation for the relief of angina pectoris. Joe is shown as a gardener on the hospital grounds, a task to which he has been assigned so that he may be under observation.

Deaths From Tuberculosis Decline

Deaths from tuberculosis in the nation decreased in 1934 although the disease spread in sixteen of the larger cities, according to the recently issued report of the New York Tuberculosis and Health Association. The survey, made by Godias J. Drolet and covering forty-six cities, shows a decline of 4 per cent in deaths, to a rate of 69.6 per 100,000 of population. This is the lowest yet recorded for large American cities.

Rochester Group Project Makes Rapid Progress

Group hospitalization in Rochester is moving forward with rapid strides. In the first three months, ending early in September, the Rochester Hospital Service Association, of which Sherman D. Meech is secretary, enrolled 7,827 subscribers and 7,861 dependents. It is reported that approximately 3,900 of the subscribers are employees of the Eastman Kodak Company although there are fifty other group hospitalization contracts in force. The association has set a goal of 15,000 subscribers for its first year.

The Rochester plan follows the general pattern of other recent plans, with the six leading hospitals (Strong Memorial, St. Mary's, Rochester General, Park Avenue, Highland and Genesee) as members. The group hospitalization corporation set up under New York law is a community organization although the hospitals advanced the funds to start the plan.

The contract in Rochester appears to be somewhat complicated but has not apparently proved difficult to explain. Subscribers pay $7.80 a year for the usual services for themselves. For their first dependent they pay $4.20 a year, and for dependent minor children, $3.60. The maximum charge to any one subscriber, irrespective of the number of dependents, is $15.60.

Mr. Meech, the executive officer of the association, was formerly personnel manager of Yawman and Erbe and later associated with the Travelers Life Insurance Company.

New Headquarters Found

The United Hospital Fund of New York has moved its offices to 370 Lexington Avenue, where the Associated Hospital Service and the hospital survey operated under the Fund's auspices will also have offices.

New York Dietitians Meet

The Greater New York Dietetic Association held the first meeting of the season in the dining room of the New York & Queens Electric Light & Power Company on September 17. The company served a dinner to the dietitians which had been cooked entirely by electricity. Before dinner the guests were shown the electrically equipped kitchen. After dinner a representative of the company gave an illustrated talk on cooking and baking, and a film was shown demonstrating some of the equipment in action.

Radium Plant Installed

A radium emanation plant has been installed at Cedars of Lebanon Hospital, Los Angeles. The hospital has available 900 milligrams of radium.

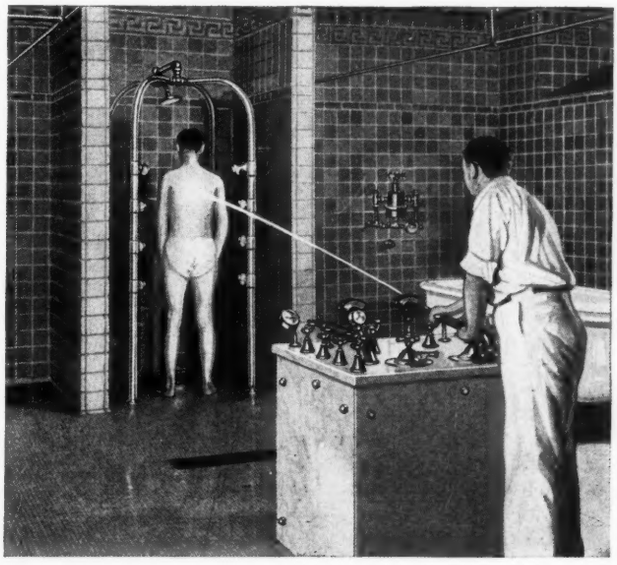
MODERNIZING FOR PROFITS

The hospital with an eye to successful operation gives thoughtful consideration to those departments which can be made to return a profit. Among these, the Hydrotherapy and Physiotherapy Department is one of the most promising. Its function is a necessary one, the treatments effective, and the equipment available at reasonable cost. Crane Co., after years of intensive investigation and research in connection with leading institutions, offers a complete hospital service in equipment for Hydrotherapy and Physiotherapy Departments. You are invited to write for full particulars on the establishment of such departments and their physical equipment. Modernization of this kind tends to pay for itself quickly. Under the Crane Finance Plan, operated under F.H.A. approval, institutions may make extensive improvements now, pay over five years.

AMERICAN COLLEGE OF SURGEONS

THE CRANE C-6101 CONTROL TABLE

Used principally in conjunction with the Hydrotherapeutic Shower, the Crane Marble Control Table is designed to enable the technician to obtain the desired temperature and centralize independent control of the hot and cold water supply to the various appliances in the department. Among these appliances are the Needle Sprays and Rain Douche Shower, Perineal Douche, Immersion Bath, Sitz Bath and Wave Spray in Sitz Bath.



CRANE PLUMBING AND HEATING MATERIALS

CRANE CO., GENERAL OFFICES: 836 S. MICHIGAN AVE., CHICAGO, ILLINOIS • NEW YORK: 23 W. 44TH ST.

Branches and Sales Offices in One Hundred and Sixty Cities

NAMES IN THE NEWS • • •

DR. ANNIE R. ELLIOTT has been appointed superintendent of Norristown State Hospital, Norristown, Pa., to fill the vacancy caused by the death of DR. S. M. MILLER. Doctor Elliott has been connected with the institution for twenty-one years and served as assistant superintendent under Doctor Miller.

C. A. SHARKEY has been appointed to the superintendency of the Buffalo Columbus Hospital, Buffalo, N. Y., a 100-bed institution. For the last four years he has been superintendent of Lakewood City Hospital, Cleveland.

RAY M. AMBERG has been appointed superintendent of the University of Minnesota Hospital, Minneapolis. He fills the vacancy left by the resignation of DR. HALBERT L. DUNN. Mr. Amberg has for several years been the assistant superintendent of the hospital.

MARY OAKS, R.N., formerly of Bartron Hospital, Watertown, S. D., has been made superintendent of nurses at St. Joseph's Hospital, Mitchell, S. D.

MRS. LOUISE SWEENEY-HECK has resigned as superintendent of Saginaw County Contagious Hospital, Saginaw, Mich. MAUDE MCRAE has been appointed acting superintendent.

HOWARD E. HODGE has resigned from the superintendency of the Decatur and Macon County Hospital, Decatur, Ill.

GENERAL ROBERT PATTERSON, Washington, D. C., surgeon general of the United States army has been named dean of the University of Oklahoma school of medicine and superintendent of the State University Hospital, where he will replace DR. L. J. MOORMAN. Doctor Patterson will resign from his position in the army to accept the new appointment.

MRS. EMMA PURSLEY, R.N., has been selected as superintendent of the new Jamestown Hospital, Jamestown, N. D. This Lutheran institution was recently opened.

EDWARD MURPHY of Tamaqua, Pa., is the new superintendent of Coaldale State Hospital, Coaldale, Pa. He succeeds DR. E. E. SHIFFERSTINE, who since the hospital was founded twenty years ago has been both superintendent and chief surgeon. Doctor Shifferstine will retain the post of surgeon-in-chief.

DR. L. J. MONTAGUE is the new superintendent of the City-County Hospital, Edinburg, Tex. DR. C. M. WILLIAMSON, former superintendent, resigned to devote himself to private practice.

SISTER MARTINA, superintendent of St. Mary's Hospital, Saginaw, Mich., for four years, has been transferred to a similar post at St. Mary's Hospital, Rochester, N. Y. Both hospitals are conducted by the Sisters of Charity.

DR. R. H. MAYHEW, medical director of Sanatorium Gabriels, Gabriels, N. Y., for the last thirteen years has resigned from the position. His successor has not yet been named. During Doctor Mayhew's tenure of office the capacity of the sanatorium has been increased from 48 to 142 beds.

DR. HUGH A. BEAM has been appointed medical director of Rock Island County Tuberculosis Sanatorium, Rock Island, Ill., succeeding the late DR. ARTHUR T. LEIPOLD.

DR. GEORGE MOGRIDGE has resigned as superintendent of the Institution for Feeble-Minded, Glenwood, Iowa, and DR. HAROLD B. DYE, assistant superintendent will succeed him.

MRS. ZORA MCANELLY FIEDLER, R.N., has been appointed instructor in the principles and practice of nursing on the faculty of the Baylor University Hospital school of nursing, Dallas, Tex.

MILDRED LENORE has resigned as superintendent of Eugene General Hospital, Eugene, Ore.

REV. AXEL M. GREEN, superintendent of Emanuel Hospital, Portland, Ore., recently received the honorary degree of D.D., conferred upon him by Augustana College for his work in the Lutheran churches.

DR. SVENNING DAHL, surgeon and founder of the Lutheran Deaconess Hospital, died recently at the age of seventy-eight.

DR. W. T. BROWN, founder of the Valmora Sanatorium, Valmora, N. M., sustained by thirty Chicago firms for their employees, died recently. He was sixty-five years old.

NINA GAGE has been appointed superintendent of nurses at Newport Hospital, Newport, R. I. Miss Gage was for some years dean of the school of nursing of Yale-in-China, and was for five years chairman of the education committee of the Nurses' Association of China. She was for three years executive secretary of the National League of Nursing Education and for four years president of the International Council of Nurses. She succeeds MINNIE GOODNOW who is best known as the author of several textbooks. Miss Goodnow is starting on a two years' trip around the world, to study nursing and hospital conditions and missionary nursing.

SISTER MARY FLAVIA, for eight years principal of the school of nursing at St. Vincent's Hospital, Bridgeport, Conn., died after an illness of eight months. She was formerly associated with St. Joseph's Hospital, Philadelphia.

LILLLIAN L. WALTEMATE, R.N., of Grant Hospital, Chicago, was recently appointed director of nursing, and LUCILEE HESTER, R.N., of Methodist Hospital, Peoria, Ill., was appointed instructor of nursing at Lubbock Sanitarium, Lubbock, Tex.

DR. BOWMAN C. CROWELL, Chicago, has been elected to succeed ADMIRAL CARY T. GRAYSON as president of the Gorgas Memorial Institute. Doctor Crowell is the author of many publications on tropical diseases and other scientific subjects. Admiral Grayson will continue his association with the institute as chairman of the board.

DR. JAMES F. BUSBY is succeeding DR. D. E. YOCHEM as superintendent of Licking County Tuberculosis Sanatorium, Newark, Ohio. For the past six years he has been senior resident physician of the William Maybury Sanatorium, Detroit. Doctor Yochem is returning to Columbus to resume private practice.

LILLIAN TRACY has assumed the duties of superintendent of nurses at San Luis Obispo General Hospital, San Luis Obispo, Calif. Miss Tracy has been acting superintendent at Golden State Hospital, Los Angeles, for a year during the absence of RUTH M. THORPE, who recently received a bachelor's degree from the University of Washington.

DR. PERRY PRIEST has resigned as medical superintendent of the Tennessee Home and Training School for Feeble-Minded, Donelson, Tenn., and DR. OSCAR S. HAUK of the staff of the Central State Hospital, Nashville, has been appointed to succeed him.

DR. HILTON R. CARR has resigned as superintendent of Shelby County Hospital, Memphis, Tenn., and will enter private practice.

J. K. BYRNE, president of the Hospital Service Association of New Orleans, died in New Orleans on September 4. Mr. Byrne had been active in group hospitalization and was also a member of the board of trustees of one of the Catholic hospitals in New Orleans.

• NOW YOU CAN BUY QUALITY CASTERS *At Lower Prices!!*

The J&J Caster has more exclusive advantages, more added improvements than any other caster made.

Welcome news for Hospital Executives! Jarvis & Jarvis has reduced the price of its Casters by another outstanding engineering achievement — standardizing a single Caster base, and adapting a series of applicators to fit into the Caster in production. You get the same fine quality at lower prices. Send for complete information today!

A Few of the *Money Saving* Casters

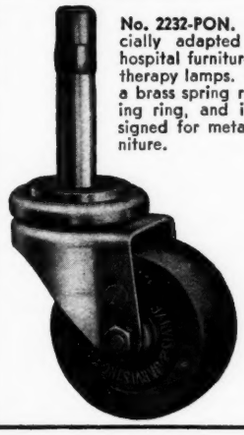
No. 2171-PON. Many types of furniture are given free rolling action by means of this caster, with its square plate which gives it a wide range of practical uses.

No. 2247-PON. This caster has a great variety of applications, such as over-bed tables, and hospital screens. It is designed for metal equipment. It never fails to give complete satisfaction.

No. 2228-PON. Especially designed for equipment heavily stressed, this caster has a pressed steel applicator which provides two-way (bottom and side) support. Used widely for linen hampers.

No. 2233-PON. This J&J Caster is used widely for tables and hospital furniture. Its live rubber cushion eliminates vibration and guarantees noiseless operation.

No. 2239-PON. An adaption of the famous J & J Super Caster. Expanding rubber applicator completely overcomes the dropping-out bother. A 500-lb. direct pull will not move it.



No. 2232-PON. Especially adapted for hospital furniture and therapy lamps. It has a brass spring retaining ring, and is designed for metal furniture.

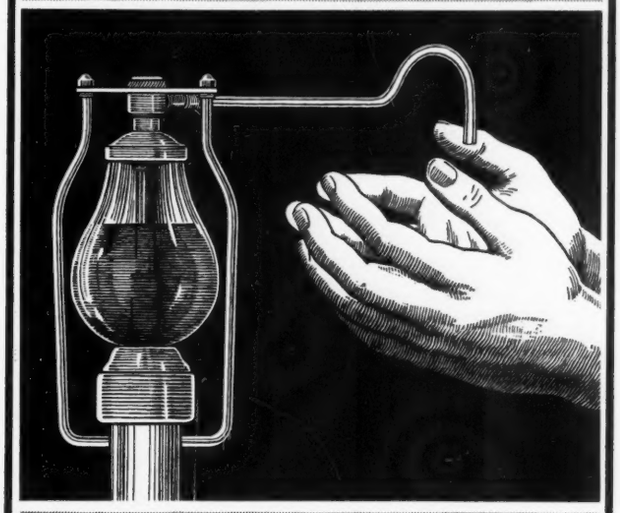
APPROVAL OFFER— **Test these new J & J Casters on your own equipment. You'll see for yourself how really fine they are. Simply specify the size desired. No obligation.**

JARVIS & JARVIS, Inc.

Manufacturers of Superior Hospital Casters and Trucks
Palmer, Massachusetts
SALES REPRESENTATIVES IN ALL PRINCIPAL CITIES

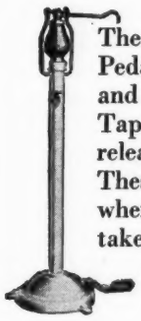
Germa Medica

Highly concentrated



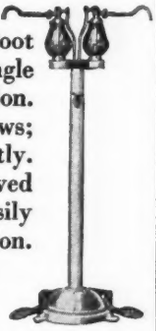
Conveniently dispensed

Germa-Medica has the highest anhydrous soap content of any liquid surgical soap made. It contains actual soap solids of 43%, and the included glycerine brings the total to about 45%. It is made without artificial fillers, and can be diluted with 3 or 4 parts water, making it very economical in use. That's why American hospitals use more Germa-Medica than all other surgical soaps combined. Truly, it's the most efficient soap your hospital can buy.



The Levernier Portable Foot Pedal Soap Dispensers*—Single and Twin—act with precision. Tap the pedal—the soap flows; release, and it stops instantly. These dispensers can be moved where desired and are easily taken apart for sterilization.

**Furnished without charge to users of Germa-Medica*



HOSPITAL DEPARTMENT

The HUNTINGTON LABORATORIES *Inc.*

HUNTINGTON INDIANA

TORONTO, ONT. 72-76 Duchess St. • 999 S. Logan St. DENVER, COLO.

Crippled Children's Institutions to Be Standardized

A law that went into effect recently in Oklahoma has brought about the creation of a state commission for crippled children. A standardization committee, composed of Dr. Maurice J. Searle, Dr. Earl D. McBride, Dr. William P. Fite, Dr. John F. Park and Dr. Walter M. Browning, has been appointed and will pass on hospitals and convalescent homes in the state qualified to care for crippled children.

The commission for crippled children will consist of the state superintendent of health as chairman, the dean of the medical school and the state superintendent of public instruction, and will probably be designated to handle the federal grant for crippled children.

The hospitals of the state have been divided into four classes, according to the type of case handled: crippled children's hospital, general hospital, standard hospital and convalescent homes.

To be approved, each institution must conform with certain standards. The amended crippled children's law now provides for medical and surgical treatment and hospital and convalescent care for children who are afflicted with any malady or deformity that can be remedied, whose parents are unable to provide it for them. Formerly this care was provided for in state institutions, but now the state will pay for this care in any institution approved by the committee on standardization.

New Home for Erlanger Hospital Is Planned

The promise of a new hospital, to replace the old Erlanger Hospital in Chattanooga, Tenn., came closer to immediate fulfillment when Judge Will Cummings of the Hamilton County Court appointed the R. H. Hunt Company and Dr. William H. Walsh, hospital consultant, Chicago, to prepare plans for the new institution. Doctor Walsh was directed to conduct a study of the needs and to assist the architects in developing suitable plans. This work was completed September 1 and the plans were submitted to the PWA authorities.

It was decided to utilize such part of the old Erlanger Hospital as is suitable for the hospitalization of Negroes, and to build a complete new unit of 300 beds, enlarge the nurses' home and mechanical plant, and utilize the present site, razing one wing of the old hospital to permit the new structure to be so located that as additional beds are needed, the old hospital may be replaced by future new wings.

While tentative plans required by the government agencies have been completed, it is intended that after the grant of funds has been made, more careful study will be given to the details by the consultant, in conference with Dr. Eugene B. Elder, the superintendent, and the members of the professional staff of the hospital. The project has been approved by the local PWA director because of the urgency of the need for additional and more modern hospital facilities in Chattanooga.

Pig Found Guilty

At Moe Hospital, Sioux Falls, S. D., a $3,000 vial of radium was recently lost and the hospital could find no trace of it. Dr. A. J. Moe, the superintendent, called for the help of two University of Minnesota scientists who devised a detector made of gold leaf and armed therewith traced the radium to the city dump grounds. There were wandering about 500 pigs. The gauge showed radium clearly, but when the pigs had been chased away it returned to normal. The scientists divided the hogs into five groups. The gauge was excited by the first group. Further eliminations reduced the group to twenty, to three and finally to the radium pig. When the animal was killed the radium tube was found in its stomach.

Improved Financial Status Results From Investigation

Dr. S. S. Goldwater, commissioner of hospitals, New York City, has compiled some figures which show income received and savings effected for the first six months of 1935 as the result of work performed by the financial investigators of that department. Doctor Goldwater says:

"While the public hospitals are primarily for the indigent sick, many injured or acutely ill persons brought in by ambulance or otherwise are found able to pay for treatment and are charged accordingly, as the law specifies. Other patients not residents of the city are expected to pay, if possible, but if too poor the state or counties reimburse the department of hospitals for their care. Further, money is received for the care of patients covered by the workmen's compensation law or those who recover damages for injuries received. From these various sources $253,000 was collected during the half-year, which is over $50,000 more than the corresponding period of 1934.

"When time permits, investigations are made before treatment and those applicants able to pay, or found to reside outside of the city are disapproved. Those rejected for maternal care and for tonsil and adenoid operations effected a saving of $65,000, which would otherwise have been spent by the city for their care and treatment.

"Voluntary hospitals which are paid for the care of some of their indigent patients had a sufficient number of submitted cases rejected after investigation to save the city over $230,000.

"At this rate the receipts and savings for the year will amount to $1,100,000, as the result of the financial investigations conducted by this department. Dispensary investigations which have been started recently are expected to eliminate improper cases which, if admitted, would cost the city not less than $100,000.

"Notwithstanding all this, the total volume of free medical care which the department of hospitals is obliged to furnish is steadily increasing in volume."

Has Attractive Annual Report

Brief, compact, attractive and inexpensive, the annual report for 1934 of the Boston Dispensary, Boston, has recently been released. It folds to the size of a leaflet, 4 by 6 inches, is illustrated with small photographs that fold down over and thus enliven the statistical material. It is an excellent example of simplicity and reader appeal that can well be imitated by other institutions. Many of them, however, will be unable to duplicate the interesting back page which describes the dispensary's service of 100 hundred years ago.

The MODERN HOSPITAL state correspondents: Alabama, Dr. Neal N. Wood; Arizona, J. O. Sexson; Arkansas, Lee C. Gammill; Northern California, E. L. Slack; Colorado, William S. McNary; Connecticut, Maud T. Traver; Delaware, C. A. Hume; District of Columbia, Dr. Edgar A. Bocock; Georgia, J. B. Franklin; Illinois, Maurice Dubin; Indiana, Albert G. Hahn; Iowa, E. C. Pohlman; Kentucky, Lake Johnson; Maine, Dr. Joelle C. Hiebert; Maryland, John E. Ransom; Massachusetts, Dr. Charles F. Wilinsky; Michigan, Robert G. Greve; Minnesota, A. M. Calvin; New Jersey, Dr. George O'Hanlon; New York State, Ernest G. McKay; North Carolina, Graham Davis; Ohio, A. E. Hardgrove; Oklahoma, R. L. Loy, Jr.; Oregon, Carolyn E. Davis; Pennsylvania, John N. Hatfield; Rhode Island, Helen M. Blaisdell; South Carolina, Graham Davis; South Dakota, Mabel O Woods; Tennessee, Dr. Eugene B. Elder; Texas, Elizabeth Kelly; Utah, H. S. Barnes; Virginia, Dr. Lewis E. Jarrett; Washington, Dr. A. C. Jordan; West Virginia, Ruth E. MacMaster; Wisconsin, Rev. Herman L. Fritschel; Wyoming, Anna G. Williams. Canadian correspondents: Alberta, Dr. E. A. Braithwaite; British Columbia, J. V. McVety; Manitoba, Dr. Gerald S. Williams; New Brunswick, Dr. S. R. D. Hewitt; Newfoundland, Dr. John M. Olds; Ontario, Dr. Fred W. Routley; Quebec, Dr. John C. Mackenzie; Saskatchewan, Leonard Shaw.

Vitalized by Nature—

Standardized by Seamless

ONLY the pure milk that comes from nearest the heart of the rubber tree goes into Seamless Standard Surgeons' Gloves—fluid rubber vitalized by nature, unadulterated. And many times during their manufacture, the gloves are checked and rechecked—standardized to meet Seamless' requirements for Seamless Standard Surgeons' Gloves.

If you're looking for gloves that will give maximum service to both the staff and the hospital budget, pick Seamless Standard Surgeons' Gloves. They will be on the job for you even after many trips to the autoclave, many sterilizations. And the staff will approve your choice, for Seamless Standard Surgeons' Gloves are "epidermically" molded. They have fit, and they afford a tactile touch that vies with the bare hand.

Here are gloves that never cramp or bind, and that stand the gaff. Seamless Standard Surgeons' Gloves come in two types: Latex, no finer made, and Brown-milled, peerless at their price. Ask your supply house for Seamless Standard Surgeons' Gloves.

SR Seamless Standard Surgeons' Gloves

THE SEAMLESS RUBBER COMPANY, NEW HAVEN, CONN.

More than 100,000 Physicians and Surgeons see this advertising every month in the Journal of the American Medical Association, Surgery, Gynecology & Obstetrics, American Journal of Surgery and Annals of Surgery.

LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D.

Another View of Health Insurance

The economic problem of a wider distribution of medical care which is necessary, available but unevenly distributed is considered from the point of view of better budgeting of cost and more stable compensation for those rendering it.* Statistics show a low percentage receiving the benefits of medical care, large sums being expended, those rendering it being inadequately compensated, yet no commensurate fall in mortality and morbidity rates.

The solution of the problem for the very poor is free care, for the wealthy it is obvious, and for public health services it is an increasing field of activities. The great problem is that of the large group who earn a living, want to pay for medical care and are unable to do so because it cannot be budgeted. Many attempts at distributing costs among the group and over a period of time, or a combination of both, have been attempted but unsuccessfully thus far.

Health insurance in Great Britain is explained and it is clearly shown that it is not state medicine. It excludes profit agencies, allows for professional control, choice of physician by patient and vice versa, as well as choice of the method of remuneration. Provision for medical service and certification of disability are advantageously separated. The suggestion is offered that the family be made the unit rather than the individual, but the author's statement "that the income limit of the insured population should be sufficiently high" takes him beyond the confines of his original thesis. He also suggests that everything necessary under the heading "medical care" should be included, namely, use of specialists, hospital care, home nursing and prescribed medical commodities.

*Sydenstricker, Edgar: The Economics of Medical Care, Virginia M. Month. Jan., 1935. Abstracted by Harold Kelman, M.D.

A Progressive Program in Medical Education

A plan known as "Medical Social Ward Rounds" was evolved at the Beth Israel Hospital, Boston, in connection with the teaching of the social implications of disease to young physicians during internship.* It consisted of correlating the purely medical aspects with the social factors, so that full consideration would be given to the patient and his illness, instead of placing exclusive emphasis on the disease. Seminars lasting about two hours were conducted jointly by a medical instructor and a medical social worker. Successive groups of three to nine students from two medical colleges participated.

Each seminar included (1) a review of the medical aspect of a certain disease, (2) a discussion of general objectives for the care of patients with the disease under consideration, (3) the presentation of several patients with the disease under consideration, (4) a discussion of the specific means of achieving the objectives outlined and (5) a recapitulation of the salient factors.

Various types of patients with different ailments were selected from the ward and from the medical instructor's private practice to illustrate the diversified problems found, not only in patients in hospital wards but also in private practice. The diseases which seemed to be of paramount importance because of their incidence and their special medical and social implications were arthritis, carcinoma, peptic ulcer, rheumatic infection, cardiac disease, syphilis and tuberculosis. Advance collaboration and preparation by both the medical instructor and the social worker made it possible for them to encourage students to raise questions, make comments and voice their aims for the future care of the patient.

The article should be read for illustrations of this interesting and progressive program.

*Cohen, Ethel, and Derow, Harry A.: Teaching Medical Students Objectives for Care of Patients and Social Aspects of Illness. Arch. Int. Med. Aug., 1935. Abstracted by Minnie Smith.

Overcoming Maladjustments in Children

Mental illness appears to be increasing. The rate of increase has been greater at the younger age levels. In the State of New York the rate of first admissions at ages under fifteen increased from 1.8 per 100,000 in 1910 to 4.1 in 1922 and in 1930 reached 5.6.

Present day psychiatry realizes that many mental illnesses have their beginning in maladjustments in young children. It is also recognized that the treatment of such maladjustments should have prevention as a principal aim. To meet this need, the New York State Department of Mental Hygiene has established a children's unit at Rockland.* This unit will accommodate 150 children, seventy-five of each sex. The buildings of this group include six one-story fireproof cottages, all connected by corridors with a central administration building.

Each cottage is similar in size and arrangement, and will accommodate twenty-five children. There is one day or living room opening out on a protected porch. At one end of the cottage there is a large dormitory. Between the day room and dormitory are the nurses' office, visitors' room, lavatory, toilet, shower and dressing rooms, coat rooms, clothing, linen and utility rooms and a suite of two rooms for contagious disease cases.

The administration building contains an auditorium with stage and dressing rooms and a projection room. There are also dining rooms and classrooms and offices for physicians and supervisor.

The area about the buildings will be used for play and exercise grounds.

The personnel will consist of two physicians, one occupational therapist, one psychologist, one assistant social worker, four teachers, one special attendant physical aid and eight graduate nurses, nineteen attendants and the kitchen help.

It is estimated that the average residence in the unit will be six to eight months.

The unit at the Rockland State Hospital will provide a much needed place for the treatment of juvenile mental disorders and perhaps will lead the way to the establishment of others.

*O'Donnell, Leo P.: Prevision of the Development of the New Children's Unit of Rockland State Hospital. Psychiatric Quart. July, 1935. Abstracted by Sidney Kahr, M.D.

Meeting Sickness Costs

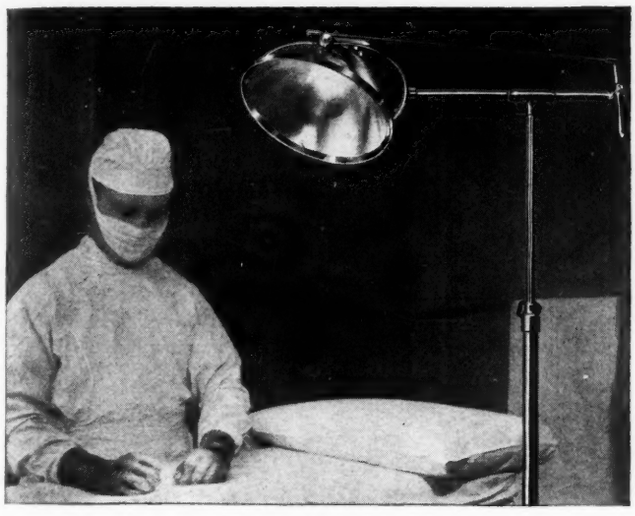
The author* briefly describes two of the methods by which hospitals in New York State are endeavoring to meet the steadily mounting costs for serving the sick in their communities.

The first method is to secure an increase in the subsidy for public charges, and hospitals in Buffalo, Syracuse and Yonkers have been granted an increase in the daily rate of payment for public charges. Other cities have similar proposals under consideration. Efforts to tap state and federal funds for patients receiving other aid from these funds have, however, been unsuccessful.

The second method is to affiliate with a hospital service plan organized under the state law enacted during 1934, which bids fair not only to increase the income of the affiliated hospitals but to broaden the base of service to groups who cannot otherwise afford to pay for hospitalization.

* Ford, C. E.: Hospitals, Social Welfare Bull. of the N. Y. State Dept. of Social Welfare, Jan. to July, 1935. Abstracted by Morris Hinenburg, M.D.

DO YOU HAVE *Complaints* ON THE OPERATING LIGHT?



If Economy Is Necessary Supplement with a Castle Spotlight

When circumstances prohibit the replacement of inadequate illumination with a large modern operating unit (like Castle Light No. 10)*, you can at least supplement present lighting with this Castle Spotlight. Castle Light No. 40 is designed to project a cool beam of shadow-reducing light having a maximum intensity in excess of 4000 foot-candles. As an inexpensive auxiliary light, it will step-up the effectiveness of your present equipment.

The No. 40 is sturdily constructed for heavy-duty service. Easy to focus. Controlled from outside the sterile field. Reflector is specially treated to prevent tarnishing.

This Spotlight is finished in non-chipping white enamel and nickel plate. Plugs into any outlet, A. C. or D. C. *Write for new brocure on Surgical Illumination.
Wilmot Castle Company, 1271 University Ave., Rochester, N. Y.

CASTLE STERILIZERS

In addition to Castle Lights, the Wilmot Castle Company is the recognized leader in sterilization equipment. Write for "Hospital Sterilizer Catalog."

CASTLE LIGHTS

APPROVED BY AMERICAN COLLEGE OF SURGEONS

YOUR PATIENTS will appreciate this "HOME LIKE" TOUCH

YOU know how important it is to make your patients feel at home—how it speeds their convalescence. And right there is where Palmolive Soap can help you. For Palmolive gently soothes fever-dried skin. It instantly produces a rich, generous lather...comforting and refreshing to the tenderest skin. And remember, Palmolive Soap is *pure*...is made only from select olive and palm oils *and nothing else.* Patient preference...gentle, speedy cleansing...*purity*—Palmolive Soap has all three!

Of course, soap is only a "little thing"—yet it is surprising how much the sight of the familiar olive green cake of Palmolive adds to your patients' comfort. The majority of them probably use Palmolive at home. They prefer its gentle, extra-generous lather . . . its pure, soothing, cleansing action.

And you can supply Palmolive at no additional cost! For Palmolive, with all its better quality and greater popularity, costs NO MORE than less favored brands.

Let us send samples and prices in the sizes and quantities you use, without obligation. Just see how inexpensively you can supply this detail of "Patient Comfort"—Palmolive. Write today.

HERE IS A FLOATING SOAP THAT REALLY LATHERS WELL

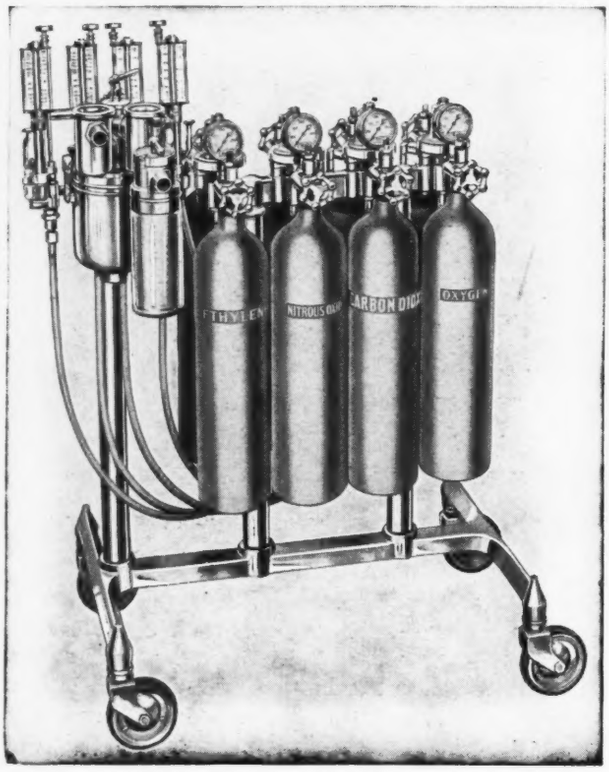
If you prefer a floating soap, just try Colgate's Floating. You're sure to like it, particularly because of the speed and ease with which it bursts into a heavy, creamy lather, even in hard water. It has a clean, refreshing fragrance, too. And it is absolutely pure and neutral . . . developed after consultation with leading hospital administrators and through research in our laboratories. Yet it costs no more!

PALMOLIVE SOAP

A Product of Colgate-Palmolive-Peet Co.
105 Hudson St., Jersey City, N. J.
CHICAGO • KANSAS CITY • SAN FRANCISCO • JEFFERSONVILLE, IND.

The New Heidbrink

KINET-O-METER



The ULTRA-ECONOMICAL
Absorber Equipped Gas Apparatus

Revolutionizes and simplifies gas anesthesia administration.

Produces better anesthesia at greatly reduced cost. One tank of gas now goes as far as four or five tanks did using old methods.

The patient's condition is better during operation and post-operatively.

Operation is easy. A simple dry-float kinetic type flowmeter controls, measures, registers and delivers each gas independently and accurately for all types of cases.

Valuable exclusive features aid the anesthetist.

Built for 3, 4 or 5 Gases
Including Cyclopropane

FREE ILLUSTRATED CATALOGUE SENT ON REQUEST

The HEIDBRINK CO.

2633 Fourth Avenue South
MINNEAPOLIS, MINN.

BOOKS ON REVIEW

THE DOCTOR'S BILL. *By Hugh Cabot, M.D. New York: Columbia University Press,* 1935. *Pp.* 299+xii. $2.50.

This book is well named. Although he deals with the economics of all medical services, Doctor Cabot's chief contribution is his discussion of physicians' practice.

Following an outline of the development of medical specialization, with its need for coordination, there are presented the available data on medical personnel and facilities for the United States and the costs of medical care among different economic groups. These chapters lead to the need for group practice and group payment and a résumé of health insurance and public health provisions in European countries.

Doctor Cabot concludes that health insurance is necessary to make medical service available to employed persons and their families, but he prefers voluntary participation to plans made compulsory by legislation. Taxation must be relied upon to an increasing extent in the care of the indigent and control of communicable diseases. The medical profession should control the professional phases of medical care and expect adequate public support. The public should provide a firm economic basis of medical service and make possible high standards of care. He does not fear lay domination of medical care through systematic payment, but recognizes that the general public has an important interest in the health of the citizens.—C. RUFUS OREM.

SVENSKA LASAVETTSBYGGNADER (*Swedish Hospitals*). *By Gustav Birch Lindgren. Stockholm: Bröderma Lagerström,* 1934. *Pp.* 288. 23½ *krona.*

While this book is written for the Swedes by a Swede, it is a valuable document in any language, for the language of photographs, plans and drawings is international.

The Swedish hospitals are almost entirely operated by the government and for that reason perhaps are, on an average, larger than ours—187.5 beds as against ours of 85.5. The smaller medical and administrative services are a reflection of the differences in medical and administrative controls. The small number of maternity beds or their absence reflects the midwifery of the Swedes.

And any physiotherapist would be heartened to see hospital after hospital with 50 per cent more space for their gadgets than is to be found in the operating departments (physiotherapy average for five hospitals, 363.10 square meters, operating departments in the same hospitals average 231.38). These data are gleaned from a remarkable set of tables giving the *golvyta* or floor area of the individual rooms, of the total and of the area per bed of every department in the hospital for each of ten hospitals.

Another beautifully done job is the set of traffic diagrams showing the travel of patients, visitors, doctors, food, and laundry, through the hospital, and the detailed diagrams of the "manufacturing" process in kitchen and laundry.

Sweden has much to teach us—the plentiful supply of day rooms, the liberal open air balconies, the always well lighted and ventilated corridors are a goal from which we are still distantly removed.

It's curious, however, that the excessive cost and unsatisfactory results of housing personnel in hospital buildings has not occurred to the Swedes. In some hospitals the surgical nurse lives in the operating suite.—CARL ERIKSON.

EASY TO BUY
Up-to-Date Coffee Makers

*Very Liberal Terms**

Continental Urns

Hospitals are pardonably proud of every item of modern equipment which their budget will allow them to add. It increases their ability to serve the public, both efficiently and scientifically.

An Important Part of Your Service

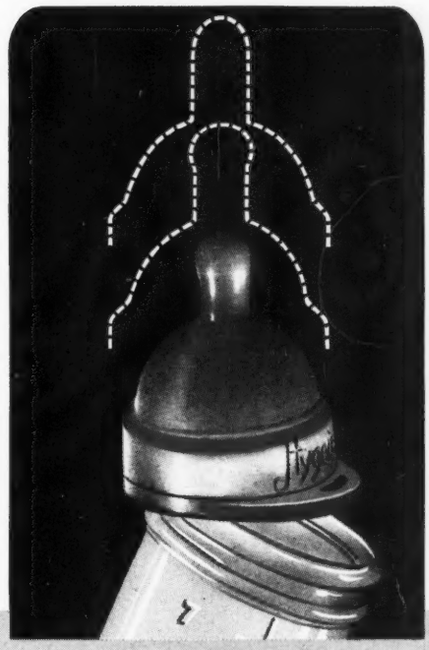
Convalescing patients require careful attention in the matter of diet. Their food must be tasty and attractively served. The coffee they drink will either add to or subtract from the pleasure of their recovery. Good coffee making equipment is your assurance that your institution can render the best possible service in this regard.

Continental coffees have been preferred for nearly a quarter of a century by important hospitals and institutions throughout the Middle West. A representative from our institutional division will be happy to call on you at your request.

*** The above illustrated coffee maker can be purchased on terms of $2 per week payable with your coffee bill.**

ALWAYS
CONTINENTAL COFFEE
AMERICA'S LEADING INSTITUTIONAL
Serve FOUR TEST

375 W. ONTARIO ST. CHICAGO



2 NEW SHAPES TO HELP AVOID WIND SUCKING

***"*If the baby swallows air while nursing and vomits, a different nipple should be tried.*"**
Morse, J. L., Wyman, E. T. and Hill, L. W.

TO MEET this need we now offer the three shapes of teats shown above. One of them will conform to the shape of practically every infant's mouth and help reduce windsucking.

SAFEST — BECAUSE EASIEST TO CLEAN. If mothers were never careless, if they always sterilized and thoroughly washed bottles, brushes and funnels, if the same safeguards were always present in every home as in your hospital, almost any bottle or nipple would do.

Unfortunately even the most painstaking mothers may some time neglect some part of the daily routine of preparing the formula. The danger of gastro-enteric infection from this source — *carelessness* — is always present.

You can help eliminate this danger. Start the baby with Hygeia Nursing Bottles and Nipples. They are *safest* because they are easiest to clean.

BOTTLES: 8 oz. size 15c; 4 oz. size 10c: liberal replacement offer on bottles broken *from any cause.*

NIPPLES: Three teat shapes. Three colors—black and red (15c); translucent 20c.

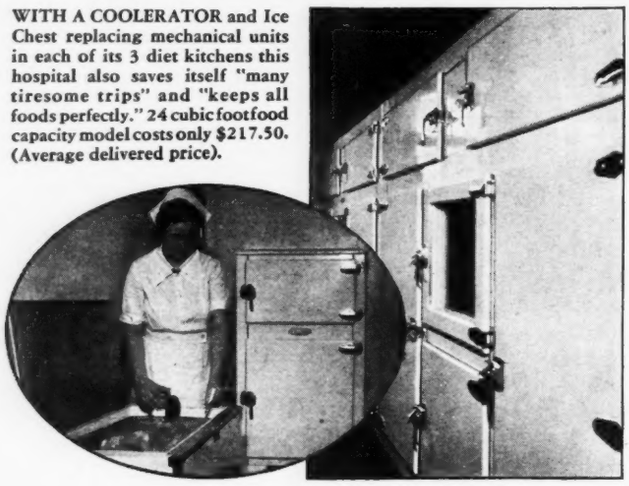
******The Infant and Young Child, Philadelphia, Saunders, 1929.*

HYGEIA
THE SAFE NURSING BOTTLE AND NIPPLE

"Expect to SAVE $2,000"

SAYS IROQUOIS HOSPITAL

WITH A COOLERATOR and Ice Chest replacing mechanical units in each of its 3 diet kitchens this hospital also saves itself "many tiresome trips" and "keeps all foods perfectly." 24 cubic footfood capacity model costs only $217.50. (Average delivered price).



...and on FIRST COST Coolerator saves 50%!

DOES it cost a lot of money to operate the new air conditioned Coolerator? Let the Iroquois Hospital (Watseka, Ill.) write the answer:

"We expect to save enough with Coolerators in 5 years to buy $2,000 worth of coal!"

This healthful, economical refrigeration preserves foods longer in their own natural juices. There's no drying out, no mingling of unpleasant odors. And you always have a plentiful supply of clear, taste-free ice.

Yet Coolerator, completely air-conditioned, costs only about one-half what you'd expect to pay. See why modern hospitals everywhere are adopting it. Try any model in your hospital for 10 days free. Just call your ice company or clip the handy coupon below.

Coolerator
The Air Conditioned Refrigerator

SEND FOR MONEY SAVING FACTS

Coolerator Co. Dept. M-2, Duluth, Minn.
Send illustrated booklet on new air-conditioned Coolerator.

Name.....

Address.....

NOTES *for* BUYERS • •

Newsworthy Surgical Dressings

Recently we asked a surgical-nurse acquaintance if she read the advertisements of manufacturers. "Indeed, yes," she returned. "I'm always shopping around for news of the new in surgical dressings."

Lewis Manufacturing Company, Walpole, Mass., accepts her challenge. They offer not only one innovation, but two — a sponge and a cotton ball. Lisco sponges, because they are of compressed cotton, absorb quickly, we hear, spread the drainage over a large area, retain the drainage adequately, and have practically no lint. All raw edges are turned in. Service Cotton Balls, state the makers, are primarily a low cost dressing. When wet, they retain an adequate amount of solution and also keep sufficient body to handle well during swabbing. They're offered in two sizes, "Large" and "Super."

Design for Shaving

The "Bantam," offered by Edward Weck & Co., Inc., 135 Johnson Street, Brooklyn, N. Y., is apparently one answer to "What's new in hospital razors?" Designed by a nurse for use by nurses and others on the staff, this razor is so small it can be slipped into the smallest kit or even into the vest pocket.

Let's scan a few of the baker's dozen points advanced for the instrument by the manufacturer: in preparing patients for the operating room, it is light, safe and dependable; it is suited for use on small wounds, skull mastoids or fractures; in the laboratory, it functions in dissection; by reversing the safety guard, it may be used with the right or left hand; finally, it is easy to clean and the blade is replaceable.

A Bed That's Friendly to Broken Bones

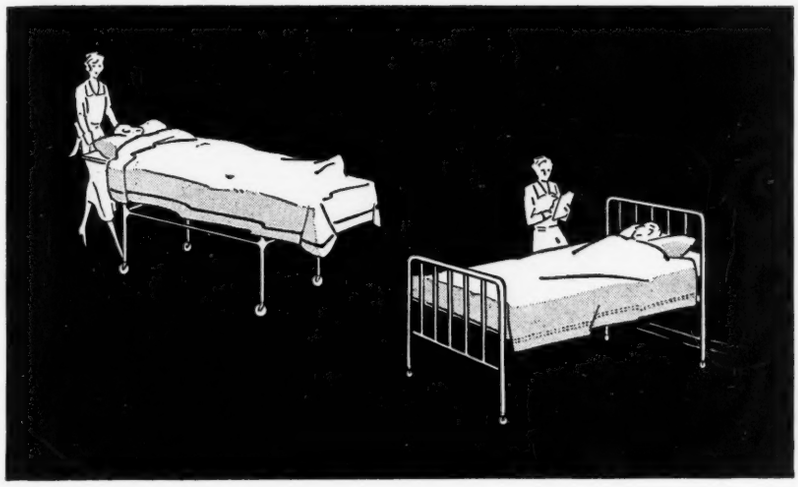
A comfortable, soft support for patients with fractures is reported to be the improved Hanflig Orthopedic bed, a product of Frank A. Hall & Sons, 118 Baxter Street, New York City. Moreover, nursing care is lightened and simplified, it is stated.

Changing the bed linen or shifting the mattress is made comparatively easy by a new method of raising and lowering the spring. This is effected by a few turns of a crank connected with a strongly constructed mechanical device and placed at the foot of the bed.

The Bradford frame slides on to the bed and can be removed and used as a stretcher. The adjustable Balkan frame is designed, it is claimed, to take care of any conceivable fracture problem. Eliminated are troublesome shock blocks, since extension stems on the casters permit the bed to be placed in an inclined position. A removable back rest and an arm support changeable to either side of the bed are added features.

A Way to Dispense Alcohol and Save It, Too

A boon for the hospital budget is the new Levernier portable alcohol dispenser which, we hear, is capable of stretching a quart of alcohol or other solution to more than gallon capacity. Heed this admonition of the manufacturer (The Huntington Laboratories, Inc., Huntington, Ind.): "A little alcohol at the right spot does more good than a lot



IN EVERY HOSPITAL DEPARTMENT . . .

FAULTLESS CASTERS

GIVE THE FAULTLESS SERVICE YOU DEMAND

Whenever you find a product in universal use, it is only logical to believe that it has outstanding merit. Faultless Casters are installed on hospital equipment everywhere for the simple reason that they have proved their superiority for hospital use. The experience gained in 44 years of manufacture is reflected in their enduring construction, smooth rolling and easy swiveling that challenges comparison. Complete comfort and protection is afforded your patients without strain on your budget—for Faultless Casters are modestly priced.

For wheel stretchers, instrument tables, beds—in the operating room, ward or laundry, there are Faultless Casters designed especially for the job. A factory representative will gladly call and without obligation show you how Faultless Casters give improved performance at reduced cost.

FAULTLESS FEATURES YOU SHOULD KNOW ABOUT

Faultless Ruberex (Cushion Tread) and Rockite (Hard Tread) wheels are of composition construction and are unaffected by heat, water, or atmospheric conditions.

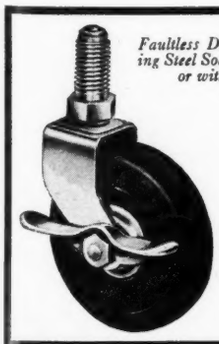
Faultless Bed Bumpers will protect your patients from jar and at the same time protect the walls of your rooms. These bed bumpers rotate freely on brass bushings and can be furnished for round, square, or grace line tubing in nearly all sizes.

Faultless Rubber Tired Wheels are sturdily designed to meet hospital conditions. Construction is simple throughout, allowing easy replacement of rubber tires when desired

FAULTLESS CASTER CORPORATION

EVANSVILLE, IND.

Branch Offices: New York, Boston, Chicago, Grand Rapids, Buffalo, High Point, N. C., St. Louis, Los Angeles. Canadian Factory: Stratford, Ontario

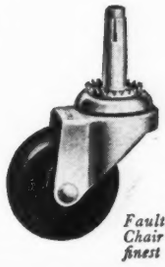


Faultless Double Ball Bearing Steel Socket Casters, with or without brake.

Faultless Expansion Socket Casters fit all metal furniture

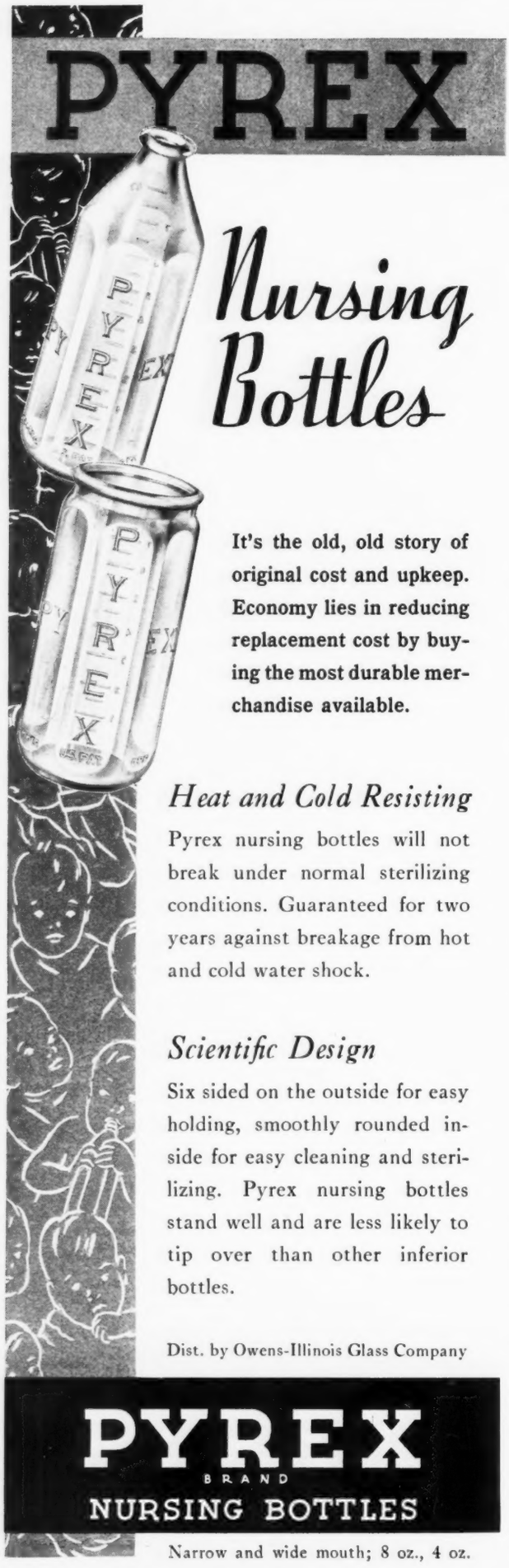
Send for Illustrated Catalog of Faultless Hospital Casters

Faultless Flexible Glides save floors, save chairs.



Faultless Office Chair Casters are finest obtainable.

Faultless Swivel Stem Casters for medium heavy duty.


PYREX
Nursing Bottles
It's the old, old story of original cost and upkeep. Economy lies in reducing replacement cost by buying the most durable merchandise available.
Heat and Cold Resisting
Pyrex nursing bottles will not break under normal sterilizing conditions. Guaranteed for two years against breakage from hot and cold water shock.
Scientific Design
Six sided on the outside for easy holding, smoothly rounded inside for easy cleaning and sterilizing. Pyrex nursing bottles stand well and are less likely to tip over than other inferior bottles.
Dist. by Owens-Illinois Glass Company
PYREX
BRAND
NURSING BOTTLES
Narrow and wide mouth; 8 oz., 4 oz.

dripping off on the floor or staining shoes and clothing."

The alcohol, we understand, is forced out of the container by pressure on a foot pedal — an operation which is noncontact — and goes exactly where it is wanted on the surgeon's hands or arms. Any residue that may run down the arm is caught by a troughlike guard and directed into a jug placed under the downward sloping channel of the guard. From the jug or receptacle the alcohol may be recovered and rectified and used for rubbing or bathing purposes.

The stroke, or what we interpret as the pressure on the foot pedal, is adjustable. This feature permits a control in amount of the solution discharged, from a teaspoonful to an ounce per stroke as desired.

"News Underfoot"

This sheet is a flash from Franklin Research Company, 5134 Lancaster Avenue, Philadelphia, telling us of "Triple Life," a new paint protector. It does what its name implies, they say—triples the life of the surface to which it is applied. Its description: a liquid, quick to apply and rapid in drying, that leaves a thin, transparent film of marked durability. Its purpose: to provide a surface coating resistant to the elements. Its use: on any exposed surface, exterior and interior, that tends to oxidize, fade or tarnish (including furniture, brass, copper and bronze surfaces).

. . . and stop! Another "flash" from this company discusses the hazard of slippery floors. In this bulletin you will find charts giving the comparative frictional resistance of various finishes tested on different types of floors by the General Testing Laboratories of Detroit. The less slippery the floor surface, the higher the coefficient of friction — but read the pamphlet for exact information which is given in detail.

Fire and Vermin Beware!

Patients in hospitals are as a rule discouraged, kindly but firmly, from going to sleep with lighted cigarettes in their mouths. Nor would one often encounter even the most fantastical practical joker applying a blow-torch to a mattress. But accidents will happen. Comes the Sleepsafe Industries, Inc., 101 Park Avenue, New York City, with a flourish of trumpets to announce the invention of a chemically impregnated mattress said to resist the most drastic efforts, accidental or otherwise, to set it on fire. Another feature of this item, which alone makes it worthy of consideration, is that the same chemical bath which renders it fireproof, also makes it inhospitable to all forms of vermin.

They Say It Cuts the Ink Bill in Half

A modern writing fluid in paste form is Permex, made by The American Crayon Company, Sandusky, Ohio. This to-be-converted-into-ink paste is the antithesis of bottled inks with regard to cost, it is said, for with bottled inks there may be comparative high transportation charges, losses due to breakage, leakage, freezing, larger storage space required and a higher initial cost. With Permex, the user buys the chemical mixture in paste form and adds the water himself, and the resulting writing fluid, we learn, is permanent in character, smooth flowing, free from sediment and of satisfactory color and texture. One may purchase this in blue-black — which is blue at the outset but changes to a permanent black. It is also available in red, green, violet and royal blue.

Now!

Saftiflasks

are SAFETY-SEALED Against Tampering!

●

The new blue Safety Seal found around the vacuum sealed closure of each Saftiflask is the *final* precautionary step taken at Cutter Laboratories to assure the delivery of SAFE Dextrose and other solutions in Saftiflasks.

Tamper-proof... yet removed in an instant!

Needless? Yes... in 999 cases... but, here is protection for the 1000th!

Yet safety sealed dextrose and other solutions in Saftiflasks cost no more than other ready-to-use solutions... and when all costs are considered, less than those prepared in the hospital.

SAFE Dextrose Solutions in Saftiflasks...

BECAUSE:

- **Each step in production and testing is CONTROLLED by skilled technicians... then each Saftiflask is Double Sealed.**
- **Each lot of bulk chemical, although certified "CP for injection" by the makers must pass rigid, self-imposed tests in our laboratory.**
- **Freshly distilled, "fractionated" water, which is pyrogen-free is used, and the mixing of each solution is controlled and checked by skilled technicians.**
- **Each batch of Cutter Dextrose, and other solutions in Saftiflasks, is tested against the possibility of any mold growth or bacterial contamination.**
- **Intravenous injection in rabbits serves as a final double check against the possibility of reactions.**
- **The various tests of solutions in Saftiflasks are the functions of departments entirely separate from the production end...hence the skilled technicians in charge of production are not confronted with the almost humanly impossible task of properly checking their own work.**
- **The background of thirty-eight years in the production and delicate testing of products for intravenous injection is your insurance against haphazard and perfunctory production and testing methods.**

CUTTER *Laboratories*

Established 1897 **BERKELEY, CALIFORNIA**

or 111 No. Canal Street, Chicago

PRODUCERS OF VACCINES, ANTITOXINS AND OTHER ALLIED SPECIALTIES FOR THE MEDICAL PROFESSION SINCE 1897

BOOTH No. 19

CLINICAL CONGRESS

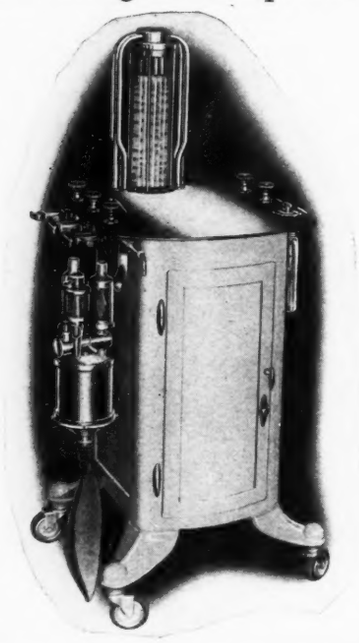
of the

American College of Surgeons

October 28th to November 1st

CABINET ANESTHESIA UNITS

Are a distinguished improvement



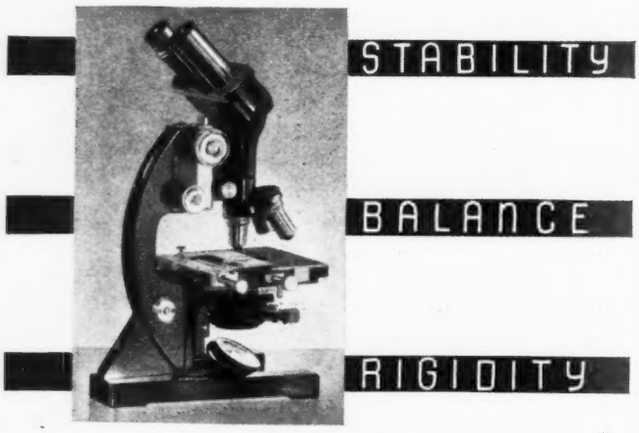
Waters Metric Anesthesia Table (Montreal Model)

The preferred apparatus for Modern Gas Anesthesia because it is the most complete and practical outfit, the use of which insures better service to patient, anesthetist and surgeon.

CABINET OUTFITS *are the exclusive specialty of*

THE FOREGGER COMPANY, Inc.

47 WEST 42nd STREET, NEW YORK, N. Y.



Essential to Hospital Laboratories

Designed especially for research work, the Bausch & Lomb G Microscope possesses those qualities essential to hospital laboratory performance. The G S Model is ideal for laboratory routine work and accessories and optics can be added practically for any type of research work.

Well seasoned glass and especially designed rulings of the B & L Haemacytometer Counting Chamber are responsible for high visibility and contrast. Mixing Pipettes which conform strictly to the Bureau of Standards specifications and optically correct cover glasses complete the B & L Haemacytometer Equipment.

Write for details to Bausch & Lomb Optical Co., 656 St. Paul St., Rochester, N.Y.

Bausch & Lomb

Progress in Analgesia

Not since before the turn of the century has scientific research contributed any outstanding development in the field of analgesic-antipyretics, reads a message from Hoffmann-La Roche, Inc., which states that four of the five analgesics most commonly used in hospitals today are over 45 years old. Nor have many people realized that amidopyrine was announced prior to 1900. For a number of years, says the message, physicians have asked for a new and better analgesic-antipyretic and this need has been met in a new synthetic, which is chemically identified as 1-phenyl-2, 3-dimethyl-4-isopropyl-pyrazolon, and which has been given the name "Larodon."

Another Hoffmann-La Roche announcement concerns a new dosage form of Prostigmin, half the strength of the solution already on the market. As its name suggests, this is for the prevention of postoperative abdominal distension. Prostigmin itself, as already marketed, is a 1:2000 solution, in buff-labeled cartons of 12 and 50 ampuls, for actual cases of postoperative abdominal distension; this strength is also used in myasthenia gravis and other myopathies. Prostigmin Prophylactic, the new dosage form, is a 1:4000 solution in blue-labeled cartons of 12 and 100 ampuls.

Other innovations are a nonnarcotic spasmolytic, Syntropan; Citro-Thiocol, containing thiocol in a new combination with codeine phosphate and citrates and narcotic exempt, and a powder form of Sedormid, and hypnotic heretofore available only in 4 gr. oral tablets.

Hospital physicians and pharmacists are invited to write Hoffmann-La Roche, Inc., Hospital Dept., Nutley, N. J., for details. In connection with Prostigmin Prophylactic, an offer of special purchasing terms has been made for a limited period.

Trade Catalogues and Pamphlets

Opportunity Knocks — With a Booklet on Keeping the Hospital Clean — Has your housekeeping personnel a hobby of collecting information on hospital cleaning? To satisfy such a desire send for the booklet, "Wyandotte Products for Hospitals and Institutions" (J. B. Ford Company, Wyandotte, Mich.) Paging through it we find hints on general maintenance cleaning (as washing painted surfaces, mopping floors and cleaning rubber sheets), culinary cleaning (as dishwashing, silver cleaning and vegetable disinfecting) and cleaning in the surgery, laboratory and the contagious ward. And there are washing formulas that are bound to capture your laundry foreman's interest.

A Fine Summary of Water Softening — Anyone faced with a water treatment problem — and what hospital engineer is not? — will profitably study "Zeolites," a bulletin offered by the technical department of The Permutit Co., 330 West Forty-Second Street, New York City, and reproduced from a paper presented at the Ninth Annual Michigan Conference on Water Purification. The bulletin, acknowledging that there is little information in water purification literature about the actual production of commercial zeolites, presents a firsthand view of present practice in the mining, processing, manufacturing and use of zeolites. Let us give you an idea of what the bulletin contains: "History of Zeolites"; "Manufacture of Synthetic Zeolites"; "Mining and Processing of Greensand (Glauconite) Zeolite"; "Hard Water and Its Disadvantages"; "Scale," and a concluding discussion of the "Uses of Zeolite Softened Water." The reprint is extensively illustrated.